

HEALTH CARE FOR THE HOMELESS: A 40-CITY REVIEW



United States
Conference of Mayors

This report was prepared by Deborah Lamm and Lilia M. Reyes at the United States Conference of Mayors with support from The Robert Wood Johnson Foundation under Grant Number 8965.

TABLE OF CONTENTS

	<i>Page</i>
Foreword	6
Background	7
Summary	9
Albuquerque	12
Atlanta	14
Austin	16
Baltimore	18
Birmingham	21
Boston	23
Buffalo	28
Charlotte	29
Chicago	31
Cleveland	34
Columbus	36
Denver	38
Detroit	42
El Paso	44
Fort Worth	46
Honolulu	48
Houston	51
Kansas City	53
Los Angeles	55
Memphis	58
Miami	62
Milwaukee	64
Minneapolis/St. Paul	67
Nashville	72
Newark	75
New Orleans	77
New York	80



TABLE OF CONTENTS

	<i>Page</i>
Oakland	83
Omaha	86
Philadelphia	88
Phoenix	91
Portland	95
St. Louis	98
San Antonio	101
San Diego	103
San Francisco	105
San Juan	110
Seattle	112
Tucson	115
Washington, D.C.	118
Appendix	121

FOREWORD

This publication represents a first, big step in compilation of data about the relationship between homeless people and their health needs. It comes about because of the progressive spirit of two philanthropies—*The Robert Wood Johnson Foundation* and the *Pew Memorial Trust*—and because of the inspiration of Mayors, health and human services providers, business and civic leaders, and many others. It comes about, too, or first, because of people who have nowhere to live.

When *The Robert Johnson Foundation* and the *Pew Memorial Trust* invited the *U.S. Conference of Mayors* to co-sponsor the Health Care for the Homeless Program, we were delighted. And surprised. Here were two foundations willing to take a chance on a very risky subject. Homeless people, almost by definition, are hard to fit into traditional molds. A national program for the homeless suggested a comparably unpredictable course. That was the nature of our surprise.

Our delight stemmed from the desire of the foundations to offer assistance to a group of people in the nation's cities whose needs were great and whose resources were marginal.

The *Conference of Mayors* applauds all who have and who will contribute to this most humane undertaking.

John J. Gunther
Executive Director

April, 1985

BACKGROUND

Since identifying homelessness as a distinct national problem almost three years ago, the *United States Conference of Mayors* has worked to keep this important issue prominent.

In a 1982 publication examining the status of human services in cities, the Conference cited homelessness as a powerful phenomenon confronting the poor, cities, and the nation as a whole. Data collected from cities around the country showed a new socio-economic group, the "new poor," who were by necessity styling a new way of life—transiency.

A mid-size Southwestern city that in 1981 boasted one of the lowest unemployment rates in the nation estimated one year later that up to 1,000 people were living in cars, trailers and tents. Some 200 to 300 people were living under bridges. These people, homeless people, presented problems to hospitals they approached for help and the schools which, in order to meet residency requirements for enrollment of children, were accepting any location, an abandoned barn, for instance, as the family's legal residence.

Long predating the expanding numbers of "new homeless" were, of course, the many, many "old homeless."

In late 1983, the *U.S. Conference of Mayors* was pleased to join two major foundations in announcing the Health Care for the Homeless Program, a multi-million dollar effort that would make funds available for provision of health services to homeless people. *The Robert Wood Johnson Foundation* and the *Pew Memorial Trust* together pledged a total of 19.4 million dollars to be distributed to coalitions in up to 14 of the nation's 51 largest cities. Awards were made in late 1984, following a competitive process. During the course of that process, the extent and severity of the problem emerged, stunning the professional advisory group making funding recommendations to *The Robert Wood Johnson Foundation* and the *Pew Memorial Trust*. The foundations responded and increased the number of awards to 18 and the total dollar amount of those awards to 25 million dollars.

Forty-five of the 51 eligible cities elected to prepare and submit

applications for awards. The applications contained unique national data about homelessness and health resources for the homeless. This publication presents a brief synthesis of the information provided in the applications about the quantity, and in some cases the quality, of health services available in mid-1984 to homeless people in this country's largest cities.

Three notes of comment:

- In many instances significantly more data were provided by applicants than is shown in the case studies that follow. Due to limitations of time and space, only select information is included. Further details can be obtained from the city contacts listed in the Appendix.
- The case studies reflect *only* information contained in the Program applications. Attempts were not made to collect additional information nor to verify the information supplied.
- Not all applicants chose to make public the information contained in their applications. For that reason, 40 case studies follow while 45 program applications were submitted.

SUMMARY

Applicant cities reported significant, sometimes staggering, numbers of homeless people in need of health care, shelter, food and general assistance. Where some cities cited homeless demographics in annual terms, others such as New York and San Francisco provided data pertaining to numbers of people without homes *on any one night*.

Several consistent reasons for homelessness were given in virtually each application. These were complemented by regional and local factors. Common causes of homelessness included: a dearth of low income housing; economic reversals, specifically changes from a manufacturing-based economy to a service-based economy; deinstitutionalization; and, cuts in federal support programs. Other conditions influencing homelessness were: attractive climate; proximity to the US-Mexican border; location as a transportation center; and, reputation as a good place to live or find work.

Health needs of the homeless were similarly uniform. It was suggested that general medical needs of the homeless follow the same patterns as those of the public at large, with some distinct and important variations. The need for disproportional amounts of emergency care and crisis intervention was proposed as one large difference between the two populations. Necessary to improve this situation are: continuity of care; access to care; mental health services; transportation; adequate financing for health services; heightened awareness on the part of care-givers; and, facilitators to ease paperwork and to work through the bureaucracy. When analyzing the health care needs of the homeless, the cities noted, it is impossible to ignore the existence of other pressing human needs that frequently influence and take precedence over attempts by the homeless to obtain health care.

The availability of health resources for the homeless was perhaps the most diverse topic covered in the applications. A few cities, Boston, for example, have established impressive service networks for the homeless, failing simply in their ability to serve the great need. Many cities indicated the availability of some health services the homeless might use. In a small number of cases, those services were actually set up for homeless

people—most often a detox center at a sparsely structured clinic attached to a soup kitchen or shelter. More often, applicants said homeless people were included in the overall population eligible for service without regard to ability to pay. This latter category of services was not seen as a satisfactory or suitable response to the homeless' health needs. Providers for the medically indigent were often unwilling or disinclined to deal with the homeless, who were viewed as difficult to treat. The homeless, on the flip side, were equally dissatisfied with these arrangements, which to them were at best unsettling situations and at worst, inapproachable and effectively nonexistent.



ALBUQUERQUE

Demographics

It is estimated that between one-half and one percent of Albuquerque's total population (341,978) are homeless. The homeless population in this Southwestern city is comprised of people from quite diverse backgrounds. They include long-time city residents, transients from other areas of the country, Native Americans who have migrated from nearby reservations, and undocumented persons from Latin America. According to information gathered through recent surveys, approximately 51 percent of the city's homeless population is White (or Anglo); 31 percent is Hispanic; 11 percent is Native American and 5.3 percent is Black. The Albuquerque Emergency Care Alliance reports that over 70 percent of the homeless have previously been in mental health or penal institutions, and that 68 percent are admitted substance users.

Over 35 percent of Albuquerque's White homeless population are transients. Since the city is at the junction of major east-west and north-south interstate highways, many people migrating to other areas in search of jobs and a better life stop temporarily in the city for any number of reasons. Over half of this group is comprised of families. Often, however, their resources run out before they can leave Albuquerque, and they find themselves destitute and in need of emergency services.

Albuquerque also has seen a large migration of undocumented aliens. At any given time, the city's homeless population includes between 250 and 300 persons from Mexico and Central America who are in the country illegally.

The city also attracts large numbers of Native Americans from nearby reservations, many of whom now find themselves homeless. They are drawn to Albuquerque in search of jobs and by the services provided at the Indian health care and educational institutions located there. Families of patients at the Albuquerque Indian Hospital who accompany them to the city are often without a place to stay while they are there.

Health Problems

Major health needs of the homeless have been identified as follows:

- *Curative medical care:* to treat various common medical problems, such as skin diseases, hypertension and infectious and sexually transmitted diseases.

- *Psychiatric care:* particularly for the many homeless persons who have been discharged from institutional and other mental health programs due to policy changes and federal cutbacks of funds.

Other services needed to address the health problems of homeless persons in Albuquerque include treatment for substance abusers, health education, and health screening.

Health Resources and Barriers to Care

Health services which are available to homeless and other indigent persons in Albuquerque include those offered by the local public health department, the University of New Mexico, the Albuquerque Family Health Care Center, public hospitals' emergency rooms, and the Veterans' Administration Hospital. Homeless persons, however, face extensive barriers in accessing these services. Those barriers fall under three major categories:

- *Access:* These barriers include lack of transportation to reach needed services which generally are not within walking distance of the shelters; the programs' limited hours of operation; long waiting periods for receiving services; and, bureaucratic protocol which requires making appointments, filling out forms, etc.
- *Economic:* This addresses homeless persons' inability to pay for health care or to qualify for Medicaid or State supported medical care available to indigent people in New Mexico.
- *Institutional:* These barriers include lack of interest and skills in dealing with the homeless among medical professionals and lack of staff time and resources needed to provide services to this population.

ATLANTA

Demographics

Atlanta estimates the total homeless population on any given day ranges from 3,500 to 5,000. Males account for 87 percent of this group; females for 11 percent; the composition of the remaining two percent was not determined. The majority of the homeless are 20 to 35 years old (57%), with the next largest age group falling between 36 and 50 years (25%). Blacks account for 63 percent of Atlanta's homeless and Whites for 33 percent.

The characteristics of the homeless in Atlanta are similar to those of other cities. Included among them are: the mentally disabled, many of whom are deinstitutionalized; substance abusers; and individuals released from incarceration (30 to 50%). Atlanta estimates over 30 percent of the homeless are unemployed. The application presumes that indeterminate numbers of homeless are transient workers, illegal aliens, young runaways, and fugitives.

Reasons for Homelessness

"The causes of homelessness in Atlanta, as in other major U.S. cities," states the application, "are as varied as the individuals themselves. The homeless community includes the mentally disabled, deinstitutionalized mental patients, alcohol and drug abusers, ex-convicts, those who are unemployed due to short-term economic conditions or lack of job skills and those who are victims of personal adversity, such as divorce, illness or accident."

Health Needs

No detailed assessment of the mental and other health needs of Atlanta's homeless was conducted. It is presumed the health problems confronted by other populations are faced by the homeless as well. In addition, the applicant coalition suggests, the homeless experience: a greater likelihood of serious illness; relatively late intervention to deal with illness; and, greater than average number of exposure related health problems, burns, wounds and emotional disorders often exacerbated by alcohol and other drug abuse.

Health Resources

Local health resources available to Atlanta's homeless include two hospitals (VA and county) and the Fulton County Department of Public Health. No health services are available directed solely to the homeless. It is estimated that five percent of the Health Department's epidemiological work is on behalf of the homeless; the same percentage of medical and surgical beds in the Veterans' Administration hospital serve homeless.

Barriers to Care

Despite the availability of health services to all who seek care at the County hospital, the applicant coalition notes homeless people generally do not seek care. Possible reasons proposed are: fear of institutions; crowds; and, waiting time.

AUSTIN

Demographics

The Austin Coalition for the Homeless estimates that between 2,100 and 4,200 homeless people can be found in Travis County, including Austin, at any one time. The city's homeless population has been categorized as follows:

- Chronically homeless (40%).
- Deinstitutionalized (30%).
- New/temporary homeless (30%).

Reasons for Homelessness

Austin's homeless include many transients from other areas of the country who have been attracted by the city's relatively low unemployment rate, mild climate and other natural amenities, and a booming economy. Upon arrival, however, these persons often discover that many of the jobs available in the city require certain skills which make them non-competitive in the local labor market.

Deinstitutionalization policies have also contributed significantly to the problem of homelessness in Austin. The release of large numbers of patients from Austin State Hospital which is located within the city is considered to have increased the number of people with chronic mental disabilities who are homeless in the community. According to an article which appeared in a local newspaper in June, 1984, "one out of every ten patients discharged from Texas mental hospitals becomes an Austin resident, and as a result the city has a larger population of the chronically mentally ill than any other Texas city."

Health Needs

The homeless poor suffer from a variety of ailments, many of which go untreated and become more of a problem with time. One local agency reports the following as being typical health problems of the homeless they serve: upper respiratory infections; skin rashes; ulcerated wounds and abrasions; and minor cuts and wounds. Among the homeless' major health care needs identified by the agency are tuberculosis tests, STD treatments, gynecological exams, and pediatric care. According to Austin-Travis County Health Department's medical staff who serve homeless and other poor people, common problems among this population include

tuberculosis, sexually transmitted diseases, malnutrition, skin infections, abscesses and ulcers, alcoholism and drug abuse, and chronic mental illness.

Health Resources

Health services available to homeless persons in Austin include those provided by Brackenridge Hospital's emergency room, by various programs of the Austin-Travis County Health Department and by two community clinics.

Barriers to Care

The homeless poor face several major barriers to receiving health care. Among them are: lack of information regarding available health services; lack of transportation which prevents them from reaching medical facilities; inability to meet established requirements for public services; and lack of financial resources to purchase medications.

BALTIMORE

Demographics

Baltimore, once a classic example of urban deterioration, in recent years has undergone a transformation, becoming instead a model of urban revitalization. Though appearances and the city's image have changed to a great extent, at least one problem, homelessness, lingers.

A number of studies of homelessness in Baltimore have taken place. They indicate the largest distinct group of homeless people in the city are single males, many of whom are substance abusers or who have some form of mental illness.

It is estimated that over 1,000 people who are temporarily or permanently homeless seek shelter at some time during each year. An indeterminate number of homeless do not seek shelter. This latter group is thought to be small, made up of relatively young individuals unable to function in society. Staff in the city's Department of Social Services see this segment of the homeless population as often "so incapacitated, lacking in minimal coping skills, that they are incapable of connecting with and using the services of our agency and those of other agencies."

A review of people aided by the Baltimore Emergency Services Board determined that of the 1,684 homeless served by the Board in 1983 and early 1984:

- 948 were adults and 697 were children.
- 55% were single individuals.
- the primary reason for homelessness was court ordered eviction, stated as the cause of homelessness in 22% of the cases.
- 16% reported informal eviction and 13% reported impending foreclosure as the reason for homelessness.
- 13% reported that they were victims of violence.
- 11% reported that they had been released from either correctional institutions, medical or mental health hospitals.
- 5% said they lived in overcrowded situations, while 1% reported that they lived in uninhabitable dwellings.
- 7% indicated that they were transients.

(Data concerning cause of homelessness were not available for the remaining 12% of homeless persons served by the Board).

Reasons for Homelessness

"There is little reason to believe that the causes for homelessness in Baltimore City differ from the causes in any other major urban area," Baltimore's application states. It continues, "Reasons for homelessness in Baltimore City include deinstitutionalization, domestic violence, formal eviction, informal eviction, poverty and unemployment, limited low cost housing, alcohol and drug abuse, and mental illness."

Sixty-six percent of 506 cases studied by the local Social Services Department of Central Maryland said they were homeless as a result of informal eviction, family conflict, release from correctional or mental institutions, or transience.

The City's Planning Department cites the following reasons:

- Decline in low cost housing.
- Closure of 14 of 18 central city low income hotels since 1970.
- Median rent levels are rising faster than the CPI and minimum SSI levels.
- Rise in the single adult population.
- Growing unemployment.
- Exclusion of non-elderly, non-disabled from subsidized and public housing.

Health Needs

Health disorders are found in over one-quarter of the self-reporting homeless. A 1983 report of the Health and Welfare Council categorizes health problems as follows:

- Physical 16%.
- Mental 30%.
- Substance abuse, primarily alcoholism 29%.
- Other 25%.

In addition, 13 percent of this group had serious hygiene problems and five percent were considered disruptive by social service workers.

Transient men studied by Johns Hopkins University, Department of Psychiatry, considered themselves in poor health twice as often as a comparison group of men living in households. Chronic diseases and the following conditions were reported among this study group of homeless men:

- Animal bites 4%.
- Skin ulcers 10%.
- Infestations 18%.
- Trauma 20%.

Less than half of the men studied tried to obtain health care for any of these conditions.

The range of health problems seen in women's shelters is broad and includes: alcoholism; anemia; dental problems; edema of the legs and ankles; hygiene problems; hypertension; infestation and concomitant dermatological conditions; malnutrition; psychiatric disorders; and podiatric problems.

Health Resources

No health services are present in Baltimore specifically geared to serve homeless people. Numerous public and private facilities and individual physicians accept and treat homeless people, however. These services are located throughout the city and are in areas where homeless persons tend to congregate.

Barriers to Care

The Baltimore application suggests the biggest barriers to care are the attitudes of the social services and health care communities and of the homeless themselves. To date, organized efforts to help the homeless in Baltimore have focused on housing and food where health services have been made available. Health care providers frequently are disinclined to seek out or warmly welcome a client who is unclean, disoriented, disruptive, and uninsured. The homeless, though often afflicted with many health disorders, are reluctant to seek care and often neglect continued treatment when it is prescribed.

BIRMINGHAM

Demographics

Birmingham officials estimate more than 12,000 people are homeless in the city. The application states that:

- Approximately 70% (8,428) of the homeless are new or temporary. These are people and families suffering severe economic dislocation, resulting from high, structural unemployment.
- About 3% (400) of the homeless are deinstitutionalized from mental health centers, largely under a federal court order in Alabama to depopulate those centers. The mental health system and the community resources have not been adequate to meet local responsibilities toward these individuals.

The 3% number for mentally ill and mentally retarded homeless persons does not reflect the true proportion of mentally ill persons among Birmingham's homeless population. The true percentage is recognized as significantly higher, and makes up a large proportion of the chronic traditional homeless, and the new and temporary homeless.

- About 25% (3,251) of the homeless are considered chronic. They are extremely low income persons and are usually "disaffiliated" from any institutional system. Included are alcoholics placed in jail for lack of detox facilities, SRO residents, and people living in abandoned, condemned housing.

Reasons for Homelessness

The primary factors contributing to homelessness in Birmingham are substandard housing, deinstitutionalization, and high unemployment. The unemployment rate given is 13 percent, down from a high of 17 percent. States the application, "joblessness has produced homelessness for some of the previously housed. Additionally, unemployment has put a larger pool of people at risk of homelessness."

Other factors relating to homelessness are due to the city's geographic location. Transients looking for job opportunities come to this regional transportation center. Also, according to reports of the local Travelers' Aid Society, SSI recipients who have questions or problems relating to receipt of checks come to Birmingham as it is the regional office for the Social Security Administration.

Health Needs

Unique health needs are present in each of three subgroups of the homeless population. Included among problems are:

- Chronically homeless:
tobacco, alcohol and drug abuse,
dental problems,
skin rashes,
respiratory infections.
- Deinstitutionalized:
mental illness,
alcoholism/drug abuse,
poor dental hygiene,
tardive dyskinesia.
- New homeless:
pediatric: upper respiratory infection, streptococcal pharyngitis,
impetigo, diarrhea.
adult: neglected acute medical problems for which medical attention has been available in the past; chronic conditions, e.g., hypertension, diabetes type 2, poor dental hygiene.

Health Resources

Sources of care are mixed, including: a public hospital and "Hill-Burton" hospital; mental health centers; health clinics; dental care through the Jefferson County Department; and, an alcoholism recovery center. Funding is largely public.

While the applicant coalition feels Birmingham has the capacity to handle most health care problems of the homeless, it indicates that the ability of the resources to deliver needed care is uncertain. This is because the system is not really designed to meet social or mental needs of homeless people.

Barriers to Care

Problems here include: inappropriate and/or unavailable transportation to delivery sites; social isolation of the homeless; and lack of available funds. For the new homeless, a major barrier to care is being forced to deal with a new situation. Having recently lost health insurance, they now are part of an indigent care system that pride prevents them from using well or using often.

BOSTON

Demographics

Based on two studies, one in early 1983 and one later that year, it is estimated that Boston has between 6,000 and 8,000 individual shelter users over a year-long period; on a single survey night, over 2,700 homeless people. Of shelter users, 20 percent were women and 80 percent were men.

The majority of homeless individuals appear to have been in Boston for years, many have grown up in various neighborhoods of the city. This was true for just over 50 percent of the men and for nearly two-thirds (63%) of the women. Many more, although claiming other origins, had been in the city for many years and, for all intents and purposes, were residents of the city.

For a great many of the guests in Boston shelters, homelessness has become a way of life. Nearly half of those who frequent the shelters have been on the streets for a period of six months or longer and one-fifth for more than two years. A large portion of the homeless population is comprised of individuals described by shelter directors as "regulars," who have stayed at one shelter or another around town over a long period of time and who are familiar faces and personages to those who provide the care and services to the homeless. Although the homeless population is extremely heterogeneous, a demographic profile provides important information. The population has a median age of about 34 years old, is largely male (four-fifths male to one-fifth female), and is unconnected to spouses or families (41 percent are single and 48 percent are either divorced, widowed or separated). While about half the population has children, only about one-quarter see their children on a regular basis. The educational levels are surprisingly high: 31 percent say they have a partial high school education or less; 38 percent report graduating from high school; and 31 percent say they have had some years of college or are college graduates.

The clinical assessment also showed that up to 90 percent of shelter guests have severe and chronic mental health problems. Major mental illness, alcoholism, and various other psychological difficulties are facts of life for most who inhabit the city's shelters. There is a core group (roughly 40 percent) who suffer from major mental illness as a primary diagnosis, and whose problems are long-standing and are profound.

About 30 percent of the homeless population have a primary diagnosis of chronic alcoholism. A majority of these individuals have been detoxified one or more times, many within one year. Although the median age among the alcoholic population is slightly higher than the shelter population in general, it is also noteworthy that this population includes many *young* adults—men and women in their late teens, 20's and early 30's. Less than 10 percent of the homeless have steady jobs. In addition, about 20 percent of the homeless could be described as having personality or character disorders.

Reasons for Homelessness

Boston is the home of nearly 10 percent of all the people who live in the Commonwealth of Massachusetts. With nearly 75 percent of housing units renter-occupied, the city has experienced a decrease in the number of available units while the number of people seeking apartments has risen. The housing stock has "improved" as inexpensive units are replaced by luxury residences. At the same time, the numbers of poor are on the rise.

Other factors also impact on the homeless. State policies for deinstitutionalization of the mentally ill, for example, have decreased the number of patients in residence in hospitals from about 25,000 in 1960 to 2,000 today. Many have been discharged to apartments which could not be maintained without adequate support, to lodging houses which have subsequently closed, and some even to temporary shelters.

Finally, it is important to note the inability of existing subsidized housing facilities to keep pace with the needs and demands. The waiting list for emergency housing at the Boston Housing Authority is estimated by one shelter worker to be two years. Residential facilities for the mentally ill or alcoholic which are supported by public funds, are in very short supply. Administrators in Boston area mental health programs often describe the difficulty they have trying to get patients into residential programs which have appropriate social and/or rehabilitative supports.

Health Needs

A shelter survey in early 1983 suggested a set of health needs common to Boston's homeless:

- The need for dental care is high, with 97 percent of the homeless individuals screened requiring some form of dental care.
- Nearly half of the homeless population (44%) stated a major medical need. Two categories of ailments emerged as the most prevalent: respiratory and cardiovascular illnesses. The respiratory problems mentioned included bronchitis, TB, asthma, emphysema, and undiagnosed chronic coughs. These cases accounted for 26 percent of the individuals who reported medical needs. The two

most frequently cited cardiovascular problems were heart disease and high blood pressure, which accounted for 16 percent of the population with medical needs.

- Problems of mental illnesses were prevalent. The types of health problems and the assessment of appropriate care needs suggest that there are at least three broad areas into which the provision of health care services could fall. First, there is a *public health* need: The homeless experience an increased incidence of communicable disease resulting from crowded living conditions, marginal sanitary environment and diminished resistance to disease. Examples which showed up in the survey included TB, upper respiratory infections and parasitic infections. Second, there is a need for *nursing care and oversight*: The majority of the illnesses are chronic ones which require medications and continuing oversight, supervision and health education. Examples of these include high blood pressure, seizures, and heart disorders. Third, there is a need for *emergency and/or episodic care*: Homelessness is clearly dangerous and unkind to the body, as well as to the spirit. Infected wounds and ulcers, asthma attacks, and periodic intestinal problems go hand-in-hand with life on the streets and can be managed effectively by a health care team working in the shelters.

Health Resources

Unlike most other cities, the vast majority of homeless people in Boston can obtain minimal health care in some of the sheltering facilities. Each of the large facilities (the Pine Street Inn, the Shelter at the Lemuel Shattuck Hospital, and the Shelter at Long Island Hospital) has had to develop its own program to provide on-site health care. However, these services are not adequate. They do not meet the full range of needs of the homeless.

Pine Street Inn:

The clinic at the Pine Street Inn has provided minimal health care for the homeless for many years. Staffed by a registered nurse and the clinic coordinator, the clinic is open three hours each day for the use of the guests. In addition, there is a full-time psychiatric nurse who provides counselling and referral.

Lemuel Shattuck Hospital:

A 100-bed hospital is located adjacent to the Hospital, a 250-bed Massachusetts Department of Public Health facility.

While hospital services are open to all, the focus of the mission at Shattuck is to provide health care to the underserved populations of Greater Boston; among these have always been a number of homeless individuals.

Medical staff provide medical services to all guests staying at the shelter, resulting in increased utilization of both ambulatory and inpatient services by the homeless. Services specifically for the homeless include a weekly evening dental clinic and the provision of a physician's assistant to work each evening at the shelter. A podiatric clinic is being planned.

Boston City Hospital and the City of Boston Shelter for the Homeless at Long Island Hospital:

The City of Boston opened the shelter for the homeless in January of 1983; intake is done each day at the Boston City Hospital (BCH).

Intake procedures begin each day at BCH at 3:00 p.m. Guests are individually screened to assess their appropriateness for this geographically distant shelter. At that time, a registered nurse provides individual health screening as well as ascertains whether or not guests who need medications have them to take to the shelter. A series of buses leave from BCH and go out to the shelter, located about a half-hour away from BCH, between 3:00 p.m. and 6:00 p.m. daily. When new guests arrive at the shelter, a more detailed interview is done by a staff registered nurse. On-site services include triage, first aid, initial diagnosis, health education, health counselling, and referral.

Emergency Rooms:

While homeless individuals receive some basic care at these shelters, the mainstay of medical care—particularly for those whose medical problems are acute or very serious in nature—is still the emergency or walk-in departments of the Boston hospitals.

Neighborhood Health Clinics:

The ambulatory clinics located in the neighborhoods of the city also are an important part of the network of health services available to the homeless. A large portion of the shelters, particularly those for families, refer their guests to these facilities.

Barriers to Care

Interviews with the shelter providers document the impediments to assuring adequate and appropriate medical care for the homeless. The following is a summary of the barriers:

- The first barrier to receive medical care for the homeless is the immense difficulty in setting up and maintaining medical appointments.
- The second barrier to receiving the necessary care is apparent when a homeless person walks through the door of a medical facility. The reception intake at medical facilities pose extremely difficult problems for homeless patients.
- When a patient gets as far as intake, the most difficult barrier to health care must still be overcome: Who will pay for the medical

services that are being sought? Very few of the homeless (roughly a little over 20 percent) in Boston are covered by medical insurance.

- Even after a homeless person has received medical services, there is a fundamental impediment to his or her speedy recovery: There is no "home" for a homeless person to go in order to rest and recuperate from illness and/or medical problems.
- Finally, when individuals or families need specialized types of medical care, there can be additional barriers to obtaining the necessary services.

BUFFALO

According to a survey conducted by the applicant, the Adult Residential Care Advocates, Inc. (ARCA), 4,407 homeless persons were served by six shelters in Buffalo in 1983. The survey also showed that Buffalo's homeless population is a "heterogeneous group of men, women, and children who are homeless due to domestic violence, alcoholism, drug abuse, mental health problems and unemployment." The city's poor economic conditions have also resulted in a sharp increase in the needs of poor people, including the homeless.

Common health problems affecting the homeless in Buffalo include tuberculosis, lice and scabies, hypertension, diabetes, malnutrition, alcoholism/substance abuse, and mental illness. Many of these problems often coexist and are chronic in nature.

For a number of reasons, homeless persons generally do not receive needed health care even though such services are available to them and other indigent persons in the community. These services include those provided by seven hospitals and several community health centers, including four funded by the Erie County Health Department.

According to the applicant, a major barrier which prevents the homeless from receiving health care is the homeless individuals' "psychological attitude and level of emotional stress related to seeking care." It is particularly difficult for homeless persons who are disenfranchised from family, friends, and other support systems to interact with the structured, organized health care system. Therefore, they are usually unwilling or unable to seek care and to make and keep medical appointments. Furthermore, regular follow-up treatment often needed in cases of chronic and contagious diseases are made particularly difficult by the homeless' transient lifestyle.

CHARLOTTE

Demographics

Charlotte's coalition estimates the homeless population to be in excess of 1,500 but determination of the exact number of homeless in the city is difficult to achieve. A Salvation Army survey of almost 1,000 homeless people in the winter of 1983-84 determined that 63 percent were White, 35 percent Black, and two percent "Other." A full 85 percent of the White population and 72 percent of the Black population had had a high school education; about seven percent of the study group were college educated.

The homeless are thought to include the chronic homeless, the deinstitutionalized, and the "new" homeless.

Reasons for Homelessness

"Homelessness in Charlotte is derived from economic difficulties, family and other social conflicts, and transients from the other areas seeking 'opportunity'." As the largest city in the Carolinas, Charlotte offers promise of jobs and upward mobility. Entry to the city is made relatively simple because of the intersection of several interstate highways and major roadways. Another factor of homelessness in this city is thought to be the growing unavailability of low income housing. The Housing Authority reports a two-year waiting list in excess of 1,500.

Health Needs

The Charlotte application states, "The health problems of the homeless in the Charlotte area run the gamut of health problems found in any population. While acute episodic incidents are prevalent, chronic ailments such as hypertension, diabetes, or congestive heart failure are the primary sources of the homeless' health problems."

Health Resources

Public and private ambulatory services are available to people in the Charlotte area. Even if individuals are unable to pay, certain services can be obtained, nevertheless. While some of these services are available to the homeless, there are no facilities that direct special services to the homeless population.

Barriers to Care

The lack of transportation is the primary barrier to care identified by the applicant coalition. As there is no organization that serves the function of coordinating travel to appropriate medical providers, the presence or lack of suitable health services does not play a major part in utilization of health care by the homeless. The applicant cites the minimal public and private funding for purchasing medication or basic medical services as another problem.

CHICAGO

Demographics

The Chicago application offers a wealth of demographic data that are briefly summarized in this section.

The number of homeless people in Chicago is estimated to range from 20,000 (Department of Housing and Urban Development) to about 25,000 (Chicago Coalition for the Homeless). In a sample survey of homeless people, the Chicago Coalition for the Homeless developed the following racial and age profiles of Chicago's homeless:

- Black 56%.
- White 41%.
- Native American 2%.
- Hispanic 1%.

The age distribution, which does not include youths, suggests 43 percent of homeless are between the ages of 17 and 35 years, 49 percent are between 36 and 55 years, and eight percent are older than 55 years.

A significant number of Chicago's homeless appear to have resided in an institutional setting at some point. A 1983 survey by the Coalition for the Homeless revealed the following breakdown for "recent" institutional stays:

- Jail 50%.
- Mental institutions 23%.
- Prison 15%.
- Other 11%.

It is thought that certain groups in Chicago contribute increasing numbers to the homeless population. A growing component of the homeless population is made up of women with children and families. At least 30 percent of the homeless in the city appear to be women. Other growing homeless subgroups are elderly and youth. Homelessness among the elderly is related to the unavailability of subsidized housing and SROs. It is thought there may be as many as 6,000 homeless youth in Chicago.

Reasons for Homelessness

There are a variety of reasons for homelessness in Chicago. The factors are not unlike those in other cities:

- *Deinstitutionalization:* The risk of homelessness is present largely because of "delays in the eligibility and payment processes for income support programs, the shortage of residential and support services in the community, and failures in linkage with available services."
- *Decarceration:* The limited availability of jobs for people leaving prisons and jails plus the scarce community facilities and support and reintegration services all contribute as factors leading to homelessness.
- *Domestic violence:* A substantial portion of homeless women are so because of domestic violence.
- *Loss of affordable housing:* An estimated 3,000 SRO units were demolished in the two years ending October 1983.
- *High unemployment:* 9.8% in January 1984-coupled with permanent loss of unskilled and semi-skilled jobs in "smokestack" industries.
- *Disparities between the standard General Assistance grant and estimated minimum subsistence standard:* In addition, applicants for GA often experience long delays between application for and receipt of benefits.
- *Federal cutbacks in a range of health and human services.*

Health Needs

The results of two needs assessments in Chicago reveal that the homeless in this city experience similar health problems as homeless elsewhere.

A shelter operator survey concluded the following problems were most severe: mental illness; nutritional deficiencies; hypertension; alcoholism; physical disability; and upper respiratory problems. At a meeting of 21 people who provide services and facilities for homeless people, priority health needs were identified and included the following: advocacy services; food and clothing; access to prescribed medications; outreach and follow-up; and linkages to health, mental health and human service providers.

Health Resources

Health services available to Chicago's homeless include both public and private services. Facilities of the Chicago Department of Health and Cook County hospitals, all public institutions, were most frequently cited by shelter operators as the source of health care for the homeless.

Free health services are available to anyone unable to pay at two health clinics in the city. Cook County Hospital runs a clinic at a residential Salvation Army Center. St. Basil's clinic is staffed by volunteers, many of whom are affiliated with Michael Reese Hospital, a large private teaching hospital. The Salvation Army clinic serves about 60 patients per day; St. Basil's serves about 100-125 people per week.

Barriers to Care

Despite plentiful health services, including some available to persons without means of payment, homeless people in Chicago frequently are unable or unwilling to obtain needed health care.

Recent budget cutbacks have made eligibility for Medicaid restrictive and, even if benefits are available, hospitalization and other services are not fully covered. This, in combination with other factors, have "reduced the willingness and capability of many private hospitals and ambulatory care providers to serve the poor, pushing this population onto the public system."

Public providers are generally unacceptable to homeless people whose physical and mental problems make it difficult for them to tolerate the conditions of understaffing, long waiting periods, etc., common to underfunded public facilities.

CLEVELAND

Demographics

The applicant coalition estimates that there are 5,000 homeless in Cleveland in any one year; an estimated 450 of these do not use shelters. A shelter survey of the 4,550 shelter users determined:

- The average age is 34 years.
- 2/3 are single men; 1/6 are single women.
- Families with two or three children make up 1/8 of shelter clients.
- 3/4 of shelter users were first-time users; only 15 percent had been without a permanent address for longer than 90 days.
- 10% of homeless people had used psychiatric services (a percentage thought to be lower than accurate by the applicant coalition).
- Almost 20 percent were from out-of-state, presumably drawn by job opportunities.
- Less than 10 percent of homeless people in shelters had contact with official human services agencies during their stay at the shelter and/or were referred to agencies when leaving the shelter.

Reasons for Homelessness

Cleveland is a city thought to contain a rising number of homeless people plus a group of individuals and families constantly at risk of becoming homeless. This situation stems from insufficient housing, large numbers of poor and near poor who have limited resources to spend on basic needs, and, an economic depression whose impact was more severe in Cleveland than in other areas of the country:

- Estimates by the Cleveland Red Cross Emergency Housing Service suggest the availability of only 2,000 low cost rental units in Greater Cleveland; only half of these are in the \$100-\$160 per month range.
- The number of low income people keeps rising, and the resources to meet their needs are limited. Over the past two years, the city's public assistance programs have expanded by about 40%. Ohio public assistance, at maximum, provides \$144 per month for an individual for food, shelter and clothing.
- The city's unemployment rate is about eight percent above the national rate.

- People with manufacturing skills are unlikely to find new work as a shift occurs from the historical manufacturing economy to one based on service sector jobs.

The previously noted shelter survey determined the overwhelming reason for homelessness among shelter users was insufficient income. The second factor was eviction. The survey yielded the data that follow concerning the reasons for homelessness in Cleveland:

- Insufficient income 46%.
- Evicted 14%.
- Transient/Chronic/Homeless 8%.
- Other 32%.

Health Needs

Health problems of Cleveland's homeless are similar to that of homeless people in other cities: chronic alcoholism; chronic malnutrition; hypertension; heart disease; mental and physical disabilities; chronic primary problems; diabetes; sexually transmitted diseases; infestations; and undiagnosed malignancies.

Health Resources

A large number of health resources exist in Cleveland designed to serve the community and those in the community who are unable to pay for services:

- Nine neighborhood based primary care facilities (four city owned and operated, one county run, three non-profit independent) with all but 13 percent of income from Medicare, Medicaid, and local taxes.
- A mobile health unit for health screening and remedial care for the elderly. This is operated by the Salvation Army.
- 15 general care hospitals.

A few health services specifically for the homeless can be identified. An 80-bed emergency shelter run by the Salvation Army has 30 detox beds and offers some podiatry services. A slightly smaller shelter also offers podiatry services.

Although many health services are available to, if not designed for Cleveland's homeless, the application states, "for the most part, these health services are *not conveniently available*, are *inaccessible*, or are *unacceptable* to the homeless. As a result, the homeless either (1) use the health care system inappropriately or (2) do not use the health system at all."

COLUMBUS

Demographics

The applicant coalition estimates that at least 9,000 people in Franklin County, which surrounds Columbus, are homeless for some period of time in the course of a year. Among the 9,000 homeless are an estimated 7,400 single adults and at least 1,600 other persons, mostly women and young children.

Only a small number of Columbus' homeless are the traditional "hard core" homeless; only eight percent have been homeless more than five years and more than half of shelter residents report being homeless less than six months. Among shelter users, nearly 93 percent are young males, and 60 percent are White and 40 percent are Black. Families seeking emergency housing are typically headed by young women, with 75 percent under age 35.

Reasons for Homelessness

Homelessness in Columbus stems from a number of conditions noted in other applications for this program including:

- Unemployment, which continues to be high.
- Changes in federal and state eligibility criteria for receiving public assistance.
- Deinstitutionalization, "a factor," the application says, "that recent studies suggest is less important here than is often assumed or may be the case elsewhere."
- The diminished will and capacity of today's smaller, more mobile family to deal with difficult members. This is illustrated by the fact that most shelter residents in Columbus have left their families because of conflict, with few indicating any expectation of returning.
- Limited availability of low income housing.

Health Needs

The application states, "Recent surveys of homeless individuals indicate that serious health problems are nearly as common as alcoholism among this population and occur more frequently than mental health problems."

A mental health study in 1984 of 72 homeless people estimates that 20 percent of the homeless have acute health care needs. The most common conditions reported in this study and in other recent studies are: respiratory diseases and other infections; heart trouble; digestive disorders; skin ailments; malnutrition; and chronic hypertension and diabetes. More than 50 percent of this group report alcoholism; 15 percent admit to drug abuse.

Of homeless families, health problems are less severe; most affected by lack of health care are children.

Health Resources

A combination of public and private resources exist to provide needed care to the homeless. Included are over 400 physicians who indicated to the local Academy of Medicine their willingness to offer care to the medically indigent at low or no cost.

In Columbus, the capacity exists to serve the homeless, but "the ability to deliver service is constrained by cost. The movement to control costs through competition could create a disincentive to treating resourceless persons unless some way is devised to distribute the burden equitably among health care providers."

Barriers to Care

Reliance on emergency services and discontinuity of care result from barriers to health care. Among barriers to care listed in the coalition's application are: disorganization of homeless people's lives; lack of resources; occasional refusal of medical care; and general inability of the care-giver community to relate to the homeless, and to identify needs, resources, or referral opportunities.

DENVER

Demographics

As in other cities, Denver's homeless population is comprised of several subgroups. They include older persons who have been displaced from single room occupancy hotels, families who have been evicted or have arrived in the city looking for work but have been unable to find it; and chronically mentally ill people who lack adequate treatment and support in the community.

A number of surveys have been recently conducted in Denver in an effort to gather demographic information about the city's homeless population. A survey of people using 10 shelters in Denver on a particular night in 1984 revealed that: 73 percent of the respondents were single males; 12.5 percent were single females; and 12 percent were families with children. Forty-six percent were between the ages of 30 and 49; 32 percent were 29 years old or younger; and 21 percent were 50 years or older. In terms of ethnicity, 57 percent of the people responding to the survey were White (or Anglo), 20 percent were Hispanic, 13.4 percent were Black and 8.6 percent Native Americans. Fifty-eight percent reported that they had either some high school education or had graduated from high school, while 21 percent reported having had some college education or having graduated from college. Forty-seven percent indicated their last residence had been a shelter, a car or that they had been living on the streets. Twenty-eight percent said they had previously lived in their own apartment.

A 1983 random sample of 786 homeless people found under bridges and in emergency meals sites revealed that the average homeless person on the streets of Denver is a white male, from out of state, between 33 and 55 years of age, with a history of recent employment and with mental or physical impairments.

Although the exact number of persons who are homeless in Denver is unknown, it is quite evident that there has recently been a significant increase in the demand for emergency services, including shelter. For example, in the first quarter of 1984 the Salvation Army experienced a 27 percent increase in the demand for lodging. Meals served by the agency during the same period increased 70 percent. Similar increases in the demand for emergency services were experienced by other local agencies.

There are currently approximately 765 emergency shelter beds, excluding those for battered women, in the Denver Metropolitan area. The majority of the shelters operate at or near capacity and are often forced to turn away persons seeking assistance because of lack of space. During the winter months, churches open their doors to allow persons to sleep in their pews. On some nights, more than 600 persons have had to sleep in churches. Even in very cold weather, homeless people are seen sleeping in doorways, under bridges, and in delapidated and abandoned buildings. Over a year's time, it is estimated that approximately 10,000 persons are homeless in the Denver Metropolitan area.

Reasons for Homelessness

There are several factors which have contributed to the growing numbers of homeless people in Denver. For example, due to the city's relatively low levels of unemployment, the high cost of basic necessities, and low levels of public benefits, many people have been unable to pay their rents or mortgages and have subsequently lost their homes. Evictions in Denver are now averaging 1,500 a month, and in 1983 foreclosures totalled over 2,000. The lack of housing affordable by low-income persons has been another major cause of homelessness. The supply of low-cost housing in the city has been decreasing as the need for such housing has been increasing. Furthermore, approximately 8,000 chronically mentally ill persons have been recently deinstitutionalized in the Denver Metropolitan area. Without adequate support systems in the community, many of these individuals now find themselves homeless. Another principal cause of the problem of homelessness has been a significant influx of people from other areas of the country who have been attracted to Denver by the city's relatively low unemployment rate. Unable to find employment, many of these individuals and families are now destitute.

Health Needs

Twenty-four percent of the homeless persons responding to the 1984 Emergency Shelter Survey reported having physical disabilities; 41 percent indicated they were experiencing substance abuse problems and 17 percent said they were experiencing mental health problems. Shelter personnel estimate, however, that the incidence of mental illness among the people they serve is higher than that perceived by respondents.

Health care providers in Denver report that infectious and contagious diseases such as tuberculosis, pneumonia, uritis, hepatitis, gastroenteritis, and sexually transmitted diseases are frequently found among the homeless population. Chronic illnesses also common among the homeless include hypertension, skin problems, diabetes mellitus, epilepsy, anemia, and heart and respiratory diseases. Due to violent acts which homeless persons are often subjected, lacerations, bruises, hematomas, fractures and burns are also often seen by emergency services providers. Lack of adequate pre-natal care has been identified as a problem among

homeless women, resulting in higher risks of babies being born with birth defects, and low birthweight, and greater incidences of premature births and infant mortality.

Many of the children living in emergency shelters are underimmunized, undernourished, and in need of medical attention. The children of teenage mothers seen at family shelters are believed to face higher risks of both health problems and abuse and neglect.

An analysis conducted over the period of a year of the health care needs of 72 families using a local shelter revealed the following information: Common illnesses identified among this group included hypertension, cancer, congenital rheumatic heart disease, and bronchial asthma. Forty-five persons were identified as having psychological problems including manic-depressive psychosis, schizophrenia, paranoia, depression and anxiety. A wide variety of prescription drugs were used by the shelter residents, with the largest number of prescribed drugs being used for psychiatric illnesses.

Health Services

The Denver Department of Health and Hospitals is the primary health care provider for homeless persons in the Denver Metropolitan area. Services are provided at the Denver General Hospital, at one of eight decentralized Neighborhood Health or Community Mental Health sites, at alcohol and drug abuse treatment facilities, and at the Department of Public Health and Preventive Medicine. University Hospital, the State's second largest provider of health care to the medically indigent, is also located within the Denver Metropolitan area. In spring, 1984, however, the hospital began to curtail services significantly in order to stay within the budget appropriated by the State legislature for health care for this population.

An analysis of Denver General Hospital's patient registration records for the month of February 1984 showed that 179 persons, including six who received inpatient treatment, registered as "transient." In March, 1984, 154 individuals registered as "transients." These counts did not include patients who gave a shelter as their address.

Barriers to Care

For a number of reasons, homeless persons generally do not receive the health care they need. Frequently, they do not perceive the need for health care. As the applicant states, "when one is without shelter and food, concern about health care is not a primary issue unless one becomes acutely ill." Shelter providers report that the homeless are often hesitant or unwilling to use available community resources, including those that provide health care. "As a result, easily treatable diseases become serious or chronic, threatening the life of the person and increasing the cost of treatment through the use of emergency rooms or the need for hospitali-

zation." Furthermore, diminishing public funding for health care for the medically indigent, at a time when this population is increasing, is another major barrier to homeless persons receiving needed medical services. This combination of factors, according to the applicant, "threatens the State's and the City of Denver's fiscal capabilities to continue to provide an adequate response to the health care needs of these persons."

DETROIT

Demographics

A recent survey by the applicant coalition estimates that some 27,500 persons were homeless and seeking shelter on an annual basis; 500 people are homeless and seeking shelter at any one time in the city. The coalition estimates further that a minimum of 4,250 homeless are alcoholics and a minimum of 1,250 are drug abusers.

Reasons for Homelessness

The application states, "Detroit, a city of more than 1,000,000 persons, has suffered the greatest impact of the recession of any major city in the nation. The unemployment rate rose from 13.0 percent in January, 1980 to 20.4 percent in January, 1983, and the 'official' rate remains at over 16 percent." In addition to severe economic problems as evidenced by the high unemployment rate, Detroit suffers from a shortage of low income housing. Furthering the homeless situation is the presence in the community of deinstitutionalized people who are unable to function and who frequently are without a permanent place of residence.

Health Needs and Barriers to Care

The health needs of Detroit's homeless are typical of those of homeless people in other large urban areas. Included among health related problems are the absence of a central agency responsible for referring homeless people to needed and appropriate medical care, the restricted financing available to support health services for the homeless, and limited transportation to health facilities.

The most significant health problems of the homeless in Detroit are: acute infections; skin infestations; trauma; peripheral vascular disease; cellulitis; leg ulcers; tuberculosis; chronic diseases; and, sensory loss. The need to provide follow-up care for certain of these problems presents a difficulty for the homeless.

"In summary," the application concludes, "Detroit's homeless experience the medical problems common to the homeless in most large cities, but also have demographic and epidemiologic characteristics specific to this city; the homeless are highly concentrated in a small geographic area and because of the extreme winter weather cannot truly live outdoors for five months each year during which they experience significant prob-

lems resulting from exposure. Specific obstacles and opportunities exist for each of the major categories of problems and require creative and coordinated approaches to service delivery planning in order to provide continuity of care to the homeless population."

Health Resources

Health service for the homeless in Detroit are limited. With the exception of a Salvation Army Clinic which operated a few months and closed, the only care has been episodic in nature and found in hospital emergency rooms. Two hospitals provide the bulk of care, a religious institution and a private institution. Although the City Health Department operates eight primary care health centers, none are located in the area with the highest concentration of homeless. The only other sources of possible care are five non-profit clinics, including the closed Salvation Army site, which provide care to all in need.

EL PASO

Demographics

El Paso's homeless include both the long term homeless and the economically marginal who "drift between the streets, cheap hotels, family and friends' homes, or between El Paso and Juarez." Based on national estimates concerning the typical percentage of any city's population who are homeless, El Paso assumes it has between 2,400 and 4,800 homeless individuals.

Combining data generated by local sources including the Police Department, Department of Human Resources, downtown merchants, hunger coalitions, and other groups, the applicant coalition assumes:

- 20-25% of homeless are elderly.
- 1-15% are deinstitutionalized.
- 15-20% are below 21 years of age.

The local coalition for the homeless provides the following estimates:

- 35% new, temporary homeless.
- 30% substance abusers.
- 15% chronic, traditional homeless.
- 10% deinstitutionalized.
- 10% other.

Reasons for Homelessness

Geographic and economic factors influence homelessness in El Paso. As a border city, large numbers of people cross to the U.S. to join the unskilled and semi-skilled labor force. Included are legal as well as illegal aliens who contribute to the number of resident jobless and homeless people. El Paso serves as a major transportation route, encouraging transients to pass through, often to remain. Finally, homelessness has been impacted by an increase in the unemployment rate, a drop in Mexican oil prices and subsequent devaluation of the Mexican peso.

Health Needs and Barriers to Care

The homeless in El Paso have a single source of medical care, the emergency room of a public hospital. Health problems seen stem from the environment of homelessness. A study of 188 homeless emergency

room patients seen in the spring of 1984 resulted in the following diagnoses: 15 percent seizures; 14 percent lacerations; 12 percent infections; and, eight percent alcohol abuse. The coalition feels that many of the health problems of the homeless could be improved or eliminated if medical care were available on a continuous basis, in non-emergency situations.

FORT WORTH

Demographics

Fort Worth estimates that two percent of the population, or eight to 10,000 people, are homeless. Of these, 20 percent are "new" homeless, 50 percent are deinstitutionalized, and the remaining 30 percent are chronic, traditional homeless. It is thought that 60 percent of the city's homeless people are single men, single women, or childless couples.

Reasons for Homelessness

Local characteristics seen as influencing homelessness include:

- Insufficient shelter (low cost housing for individuals or families).
- In-migration and population growth accompanied by a high rate of unemployment (5.7%).
- The high proportion of the population with incomes below poverty level (40%).
- Increasing numbers of abandoned women and children.
- Deinstitutionalization without adequate community based services.
- Non-emergency health care limited to a few sites; they are not available at all times.

Health Needs

Health needs of the homeless in Fort Worth are thought to be as follows:

- Chronic mental illness 50%.
- Acute health problems 20%.
- Substance abuse 20%.
- Acute mental problems (depression and stress) 15%.
- Battered women 5%.

Health Resources

Health services in Fort Worth include public and private doctors, hospitals and clinics. A range of curative and preventive services appear to be available to persons who are in need, regardless of ability to pay. No services are targeted to the homeless.

Barriers to Care

The application lists specific health problems and direct barriers to care. The list is below:

- *Alcohol and drug abuse:* Texas Christian University's assessment of the needs of Fort Worth shows only 582 cases of drug abuse treated, even though 18,000 families indicate this is a problem. Few agencies and poor referral coordination are barriers to this kind of service.
- *Mental illness:* (deinstitutionalized with medication and counseling needs) Barriers are lack of sufficient facilities and lack of transportation. It is estimated that 10 percent of mental health presentations are acute situational crises and 90 percent are chronic, including personality disorders, affective disorders, and schizophrenia.
- *Malnutrition (children):* Barriers are lack of more well-baby services, inadequate nutrition programs for women, infants and children (WIC) and lack of transportation.
- *Acute health problems (colds, flu, minor infections, minor trauma):* Barriers are lack of medical providers who do not charge fees, red tape for determining eligibility, long waiting periods for appointments, excessive waiting, limited hours of availability, and lack of transportation.
- *Chronic health problems (diabetes, hypertension, arthritis, etc.):* Barriers are the same as found for "Acute health problems."
- *Dental:* Barriers are lack of sufficient services, and transportation, and verification of eligibility stringency. Clinical problems include periodontal disease, caries, missing teeth and lack of dentures.
- *Childhood diseases:* Barrier is transportation. Delayed immunization protection is common.
- *Tuberculosis:* Barriers are transportation and patient cooperation with a lengthy course of therapy. Current case registry for tuberculosis contains 87 homeless persons.
- *Prenatal care:* Barriers are the same as found for "Acute health problems."
- *Trauma:* Barriers are the same as found for "Acute health problems."

Other barriers to providing health care to the homeless should be addressed. They are:

- Lack of continuity of care and follow-up.
- No funding for needed medications.
- 24-hour waiting period for crisis mental health needs.
- Lack of client advocates.

HONOLULU

Demographics

Honolulu often evokes images of a vacationing "paradise." For the 2,500 individuals estimated to be homeless in the city, however, it is quite a different reality. Honolulu's homeless include single persons and families, runaway youths, elderly people and abused spouses. They also include military veterans and their families, recent arrivals from the Mainland, former patients of Hawaii State Hospital, chronically mentally ill persons, alcoholics and substance abusers, stranded travelers and recently arrived refugees from Southeast Asia and other areas. The homeless in Honolulu are living in temporary shelters, on the beaches, in tents or in caves.

Surveys of service providers indicated that about 30 percent of Honolulu's homeless are living on the streets, 15 percent on the beaches or in caves, and 20 percent in temporary shelters. Five percent are runaways, 5 percent are elderly, and 10 percent are abused spouses. Stranded tourists and people living temporarily with relatives are thought to make up the remainder of this population. At least 50 percent of Honolulu's homeless are believed to be mentally ill.

Reasons for Homelessness

Major causes of the problem in Honolulu include the following:

- *Severe shortage of housing, particularly for low-income people:* According to a 1982 study, at least 40 percent of Honolulu's households are in need of housing assistance to correct overcrowded, sub standard housing conditions and/or to meet housing costs. The city has almost a 99 percent occupancy rate and an average rental rate that is at least 40 percent above the national average.
- *High cost of living:* The "lower" budget for a four-person family living in Honolulu is estimated to be 33 percent above the national average.
- *Limited employment opportunities:* Of the 324,113 individuals who were employed in Honolulu in 1980, 71 percent held more highly skilled positions such as in the managerial and professional specialty fields, technical sales, administration and repair trades.
- *Migration from the Mainland:* Honolulu sees a continual migration of persons who leave the Mainland in search of a better life. Once

they arrive, however, many exhaust their resources before they can find employment and become homeless.

- *Deinstitutionalization of the mentally ill:* This group, which constitutes a large part of the homeless population, lacks needed support services in addition to emergency assistance.
- *Ethnic considerations:* Residents of the Polynesian Islands who migrate to Honolulu often have difficulties adjusting to an urban lifestyle which is very different from their traditional way of life. Many subsequently become "stranded" and become part of the homeless population.

Health Needs

Health services providers who treat the homeless in Honolulu gave the following information regarding prevalent types of health problems experienced by this population. According to reports from hospitals' emergency rooms, about 75 percent of the homeless they see are diagnosed as suffering from psychiatric illnesses. Many are admitted to the hospital because of suicidal gestures. Other problems include abrasions and lacerations as a result of assault, skin problems, lice and fleas, scabies, and pancreatitis. Most of the medical problems of homeless people seen in emergency rooms are considered severe and usually require some hospitalization.

Community health clinics report a high frequency of chronic foot infections due to poor hygiene and not wearing shoes. Other common problems include malnutrition and vitamin deficiencies, alcohol related illnesses such as menentia and liver disease, burns which often lead to massive infections, and mental illness. Individuals requiring medical attention usually exhibit a wide range of different health problems.

Doctors affiliated with shelters estimate that 50 percent of the homeless population have body parasites, bacterial and fungal infections and upper and lower respiratory problems. Another 10 percent suffer from hypertension and five percent have hemorrhoids. Gynecological problems were noted in 50 percent of all women at the shelter and some urological disorders were noted in 20 percent of the men. Five percent of the homeless population are in need of surgical care, and at least 50 percent have some form of mental illness, the doctors estimate.

Skin infections, body lice and communicable diseases are among the health problem frequently presented by runaway youths. The effects of prostitution and the prevalence of venereal diseases among this population is regarded as a serious health problem.

Health Resources and Barriers to Care

Honolulu has five hospitals and five clinics which provide some medical care to the homeless. However, homeless persons face many

obstacles which reduce their chances of receiving health services. The lack of adequate and appropriate outreach is considered to be one of the principal barriers. According to services providers, homeless people usually will accept services they are offered in familiar surroundings but not in formal medical settings.

Homeless persons' inability to pay for services is also a major obstacle to homeless persons' receiving care. Although they are in dire need of assistance, the homeless face great difficulties in accessing into the Medicaid system because of the bureaucratic paperwork involved and the program's eligibility requirements. Even when these requirements are met, there is a long waiting period (about 45 days) before a person is eligible to receive benefits.

Another important barrier to homeless persons receiving needed health services are negative attitudes found among health professionals regarding serving this population. As the applicant indicates, "there is little incentive (for them) to treat a population like street people who are usually (unclean) and without economic resources." There is also a need for health care providers to receive education and training regarding how to treat "this special and unique population of disenfranchised citizens" which might involve non-traditional approaches.

Transportation problems create an additional barrier. Honolulu's limited public transportation system, which covers only the major roads at certain hours, in addition to the cost of transportation services, prevent many homeless persons from accessing health care. For homeless persons in the outlying districts of the city, health agencies are even more inaccessible.

When health care services are provided to the homeless, they tend to be only emergency interventions. Homeless individuals in need of health care usually do not receive comprehensive examinations or screening. Also, because it is difficult for health care providers to maintain contact with many of the homeless persons they treat, follow-up care is rarely provided.

HOUSTON

Demographics

Houston's coalition conservatively estimates the number of homeless in Houston to be between 6,000 and 7,000 individuals. Homeless males are thought to fall into one of four categories:

- Drug and alcohol abusers (50% of all homeless men).
- Chronically mentally ill, deinstitutionalized (25% of all homeless men).
- New poor (15%).
- Chronic homeless/street people (under 10%).

A four month effort was begun in late 1983 and early 1984 to collect data on Houston's homeless. The study, by the Winter Housing Shelter Program, was funded by the Federal Emergency Management Agency, United Way, and area church donations. It determined the ages, racial characteristics and job skills of homeless men. Thirty-nine percent of the men were White; 29 percent were Black. More than one-third were between 25 and 34 years old. Fifty-six percent of men indicated they were unskilled; 28 percent reported some skill or training. Nearly 50 percent of men surveyed were residents of Greater Metropolitan Houston.

Reasons for Homelessness

Homelessness in the Houston project service area and the surrounding Harris County is the result of typical circumstances including: an economic recession, deinstitutionalization, shortages of low income housing, and new restrictions regarding public assistance benefits. In addition, the number of homeless people has grown because of conditions unique to the Houston area. The oil-based economy of the region expanded when other parts of the country experienced recession; this led to an influx of job seekers, whose number greatly outnumbered the number of available jobs. In addition, the recession that had impacted on other parts of the country earlier began affecting Houston, leading to layoffs and firings. All of these factors combined, causing a ripple effect for other parts of the local economy.

Health Needs

Health needs of Houston's homeless as identified by the applicant

coalition are comparable to those of homeless people in other communities. The majority of health complaints were of undetermined origin and required diagnosis from hospital medical staff. Chest pains, back pains, and leg pains were the most common complaints verbalized. Bruises, sores, and burns that have gone untreated and became infected were also a common problem. Infestation of lice was common because of living and sleeping arrangements and the highly contagious nature of the disorder. This condition is frequently passed from one individual to the next. The problem often recurs in men who have been treated. Many of the men with diagnosed problems of hypertension, tuberculosis, or diabetes were aware of and educated about their health problems, but due to the disordered living arrangements, continuous and consistent care is not obtained.

Health Resources

A variety of public health programs exist in Houston and surrounding Harris County for low income people. It appears that while the homeless may use them, these services are not designed specifically to meet their needs. Free preventive care and certain disease-specific services are available in the county and municipal health centers. Additionally, hospital and ambulatory services are provided to legal residents of Harris County on a sliding fee scale. A county program is operated to offer medical services to individuals who are temporarily unemployed. More than 1,000 physicians volunteer services for this effort. Public mental health services are also available to high risk individuals.

Barriers to Care

The applicant coalition notes "The barrier to health care in Harris County consists of the lack of transportation, the lack of knowledge concerning the availability and location of appropriate health services, and the eligibility processes that are required before medical care can be provided."

KANSAS CITY

Demographics

The Kansas City Coalition of Agencies for the Homeless has defined the city's homeless population according to the following categories:

- *Persons served in temporary housing:* This group is comprised primarily by the "traditional or chronically" homeless. However, it also includes a substantial number of "new and temporary" homeless individuals. Approximately 7,060 homeless persons are housed annually in temporary housing in Kansas City.
- *Persons served in transitional facilities:* Individuals served by these facilities are primarily chemically abusers, ex-offenders, and mentally ill persons who have been deinstitutionalized. The majority of these individuals lack resources necessary to maintain reasonable accommodations outside the residential setting.
- *Displaced women and children:* A growing number of women and children are becoming homeless each year primarily as a result of domestic violence. Approximately 1,960 battered women and their children are served annually by three local shelters.

Health Needs

According to the Coalition, the homeless' "health problems are related to environmental, economic and personal lifestyles which lead to situations and behavior unfavorable to maintaining good health. Inadequate shelter, deviant subculture, improper diet, inability to afford proper medical care and food, reliance upon drugs or alcohol, unsanitary living conditions, and personal habits, and mental and emotional problems all contribute to the continuance of self-destructive behavior, self-neglect, and hopelessness."

Health Resources

Several medical facilities in Kansas City provide health care services to indigent persons including the homeless. They include:

- Wayne Miner Health Center, which provides ambulatory health care.
- Truman Medical Center (the teaching hospital for the University of Missouri Medical School).

- Richard Cabor Clinic (an outpatient clinic).
- Swope Parkway Comprehensive and Mental Health Center.
- Veterans' Administration Hospital
- Children's Mercy Hospital.

Barriers to Care

Homeless persons, however, usually use health care services available in the community only in cases of emergencies. Bureaucratic and geographic factors often make these services inaccessible to them. Furthermore, the task of trying to meet basic needs of food and shelter becomes of higher priority than getting needed medical attention, except in cases of acute illness or injury.

Interviews recently conducted with homeless persons at two shelter sites in Kansas City revealed the following:

- Despite self-reported medical problems, which included conditions such as hypertension and peptic ulcers, very few of the homeless individuals interviewed were under continuing medical care.
- Most respondents felt that it was relatively easy for them to see a physician. Several indicated, however, that their condition had to be acutely painful before they sought care.
- The large majority of the respondents would use health care services sooner and more often if the services were more geographically accessible; if it was easier to receive services (having to wait less for services, and less bureaucratic "hassles"); and if returning for follow-up treatment was also made easier.

LOS ANGELES

Demographics

The applicant coalition estimates that at least 33,000 homeless people can be identified in Los Angeles, with the largest group, 65 percent, present in central Los Angeles. Population subgroups include:

- The chronically disabled, who suffer from drug and alcohol abuse and mental illness. Some 18,000 are thought to be in this group.
- Individuals in crisis, 29 percent, with a concentration of runaways found in Greater Hollywood.
- The economically disadvantaged. This group includes the new poor who, "like the runaways, ... are totally unprepared" for the homeless situation that takes place during their search for work. Problems include: the distance to be travelled to work combined with the inadequacy of public transportation and limited low cost housing.

Also in this group are legal immigrants who face cultural and language barriers in their search for employment and, of course, housing.

The chart on the next page represents an estimation of the percentage of each sub-group within the Los Angeles homeless population.

Reasons for Homelessness

The lack of low income housing and limited emergency shelter contribute to homelessness in Los Angeles. The application states that between 1970 and 1980, the number of low-cost dwelling units in the city dropped by about 30 percent. Another reason for homelessness is the mild climate which encourages newcomers to the city. Hollywood attracts a primarily youthful population seeking "the lure of Hollywood."

Health Needs

The application states, "the health problems of Los Angeles' homeless, in the aggregate, resemble the primary health problems of other groups in the United States in many ways... Certain health problems, however, are particularly evident among the homeless and those with very low incomes—all may be further aggravated by the inability to store medicine properly or adhere to a prescribed medical regimen or diet." Included here are cutaneous infections, stasis edema and resultant ulceration.

Homelessness Related to Chronic Disabilities

Sub-category	Estimated Number	Estimated Percent of Total Population
Alcoholics/Drug Abusers	8,910	27%
Mentally Ill	9,240	28%
TOTAL IN CLASS	18,150	55%

Homelessness Related to Severe Personal Crises

Sub-category	Estimated Number	Estimated Percent of Total Population
Runaways	2,310	7%
Battered Women	2,310	7%
Older Poor (displacement)	3,300	10%
Others	1,650	5%
TOTAL IN CLASS	9,570	29%

Homelessness Related to Adverse Economic Impact

Sub-category	Estimated Number	Estimated Percent of Total Population
"New Poor"	5,280	16%

SUMMARY CLASSIFICATION	ESTIMATED NUMBER	ESTIMATED PERCENT OF TOTAL POPULATION
Chronic Disability Related	18,150	55%
Crises Related	9,570	29%
Economic Condition Related	5,280	16%
	33,000	100%

Among children of homeless families, multiple health problems exist as most of the children are undernourished and not adequately immunized. Many homeless children have various developmental problems.

Health Resources

A plethora of health services are available to the homeless in Los Angeles, if they can get to them. The County Hospitals, in particular, are a great distance from the areas in which the city's homeless congregate. The mix of services includes residential facilities for recovering drug abusers, alcohol detox centers, residential centers for adult Indians, overnight shelters with on-site medical services and referral capability, and traditional services available to the medically indigent. Funding and sponsorship of these services represents a range of public, private and religious sources.

Barriers to Care

Delivery of services in Los Angeles is greatly affected by the lack of accessible transportation. The transportation factor in combination with the generally arduous process of obtaining publicly provided health care often results in the postponement of care. In addition, many homeless are so busy trying to find a meal and a bed for the night that they do not have the ability to address their health needs.

MEMPHIS

Demographics

A recent survey of 45 residents of the Salvation Army shelter in Memphis provided the following demographic information about homeless people in the city. The mean age of the people interviewed was 30.4 years; 64 percent were male; 69 percent single; 51 percent Black. More than half indicated they were previously employed as unskilled workers. Seventy-one percent identified Memphis as their "legal residence," with the remaining coming from six different states. Another survey of people using two different shelters and an emergency feeding site revealed that the number of White and Black males served by these programs were equally divided. White females, however, outnumbered Black women almost two to one.

Memphis' homeless population is comprised of several subgroups:

- *Chronically mentally ill:* Persons released from nearby Western State Mental Health Institute and chronically mentally ill individuals are believed to make up the largest group of homeless people in the city. In addition to the many people who have recently been deinstitutionalized, there is a growing number of chronically mentally ill persons in Memphis, many of whom are young and have drug-related problems, who have never been hospitalized.
- *Chronic homeless:* These persons, many of whom are alcoholics, have been homeless for several years.
- *Temporary homeless:* They include displaced workers and persons who are unable to find low-cost housing.
- *Transients:* A significant number of Memphis' homeless have come from other areas in search of jobs.

Reasons for Homelessness

There are several factors which have contributed to the problem of homelessness in Memphis. They include:

- *Migration of persons from nearby rural areas and small towns,* generally with low levels of education and skills, who come to the city searching for jobs.
- *Weak local economy, high unemployment, and high incidence of poverty:* According to the 1980 Census, the per capita income of Mem-

this residents over 14 years of age is \$6,706; in 1984, one out of seven city residents lived below the poverty level. The city lacks a strong manufacturing base and has suffered from high unemployment. For example, over 4,000 workers were recently laid off as a result of the closing of three plants.

- Inadequate levels of benefits and tight eligibility requirements of public assistance programs, including AFDC and food stamps.
- *Deinstitutionalization:* Since 1968, the number of patients at the Western State Mental Institute, which is located only 60 miles from Memphis, decreased from 2,600 to 540. Most of these persons have settled in the city. Many have moved in with families, others live in boarding homes or in halfway houses. Others, however, are homeless.
- A "critical" shortage of low-cost housing: The Memphis Housing Authority currently has a waiting list of approximately 4,000 persons.

Health Needs

In 1984, the Memphis and Shelby County Health Department and the Mid-Town Mental Health Center conducted an assessment of the health status of homeless people staying at the Salvation Army Mission. Of the 45 persons interviewed, 62 rated their health status as good, 20 percent as fair and 16 percent as poor. Sixteen percent indicated they had been hospitalized in the last five years, while 15 percent said they had never been hospitalized. Forty-five percent of those interviewed stated that they had seen a doctor in the past three months; 20 percent, however, had not visited a doctor in over two years. Forty percent had not seen a dentist in over two years and 13 percent had never seen a dentist. More than half, or 56 percent, felt that they were in need of dental services.

In terms of specific health problems reported by the respondents, 20 percent had been told they had hypertension, another 20 percent had arthritis, and 15 percent had bronchitis. Just under one-third of those interviewed were currently taking medications prescribed by a physician for a variety of conditions. Seven of the children included in the survey were delinquent for one or more immunizations.

Another survey conducted in 1984 revealed the following information: 89 percent of the homeless persons interviewed indicated they used hospital emergency rooms whenever they needed medical care. Similarly, most services providers referred their homeless clients to hospitals' emergency rooms. Thirty-eight percent of those interviewed said they had visited a hospital emergency room at least once in the past year. Twenty-one percent had been treated more than twice in the past year. Approximately 45 percent of the homeless persons had their prescription drugs filled in hospitals' pharmacies. Over 20 percent had received in-patient care

during the past year. Only 18 had some type of health insurance such as Medicaid or veterans' benefits.

Twenty-five percent of the homeless indicated they had one or more chronic physical conditions including arthritis, high blood pressure, diabetes, ulcers, heart problems, asthma, blood clots, glaucoma, epilepsy and chronic infections. High blood pressure and heart problems were the complaints most frequently mentioned.

Health Resources

The primary provider of health care to homeless adults in Memphis is the Regional Medical Center, a non-profit hospital corporation. Homeless children receive services primarily from the LeBonheur Children's Medical Center, the Memphis Health Center, the public health department, and the Porter-Leath Center. In addition, the following facilities provide health care services to homeless and other indigent persons in Memphis: The Memphis and Shelby County Medical Society's Project Care, through which volunteer physicians provide medical services to unemployed and uninsured persons in the community; the Memphis and Shelby County Health Department, which operates six permanent primary care clinics and eleven satellite or part-time clinics; and the Veterans' Administration Hospital. Specialty care available for children include the Memphis City School Speech and Hearing Program and Methodist Hospital Eye Clinic.

Barriers to Care

According to the applicant, "The homeless in Memphis appear to be largely outside the care system and enter it only as a last resort in a point of crisis. In the health care network, this brings them to hospitals' emergency rooms for primary care. This care is not only costly for the community but is fragmented and impersonal for the patient, perhaps reinforcing a sense of alienation. There are very few services available specifically for homeless people" in the city. Factors which prevent homeless persons from receiving needed health care services in Memphis include:

- *Limited hours of operations of health care facilities:* Most health clinics do not provide services after 4:30 p.m.
- *Overcrowded facilities:* The average waiting time for an initial appointment at some local health clinics is two to six weeks. Health department clinics are operating at capacity with the average waiting time of one to two weeks for adult acute illness care, and two months for an initial "chronic disease maintenance appointment." Cases of pediatric acute illness can be seen in two days at the Health Department but appointments for regular checkups must be made two months in advance.
- *Fragmentation/limited quality of care:* Since most of the health care provided to homeless individuals are delivered at the hospital

emergency rooms, there is generally no opportunity for follow-up treatment or for the provision of preventive services.

- *Lack of access:* Most homeless persons have no means of transportation to reach health services.
- *Special needs:* There is generally little awareness and sensitivity among health care professionals regarding the special needs of the homeless population.

MIAMI

Demographics and Reasons for Homelessness

Each year, particularly during the winter, Miami attracts tourists from other parts of the country who go South for their vacations and for relief from the cold. Miami also attracts many persons in search of jobs and better opportunities. The city's job market, however, is very competitive and, as a result, many newcomers use all their savings before they can find employment. They then become homeless and find themselves in need of emergency services. In addition to these transients, Miami's homeless population includes the following groups:

- *Chronically mentally ill persons:* Shelter providers estimate that at least three-quarters of their clients have some mental health problems and that nearly one-third have been released from an institution.
- *Unemployed persons:* These include both city residents and people from other areas who can't compete for the jobs that are available in the city because they lack specific skills required for those positions.
- *Refugees:* In 1980, Miami saw a very significant and sudden influx of Cuban and Haitian refugees who, at that time, accounted for approximately 14 percent of the city's population. While most of these persons have been absorbed into the community, many of them are in need of emergency services, including shelter.
- *"New homeless":* These people have been forced out of their homes because of cutbacks in welfare, social security, and other public benefits. Many of them have been able to move in with friends or relatives and are living in very marginal conditions, while others have been even less fortunate and have been forced into the streets.
- *"Regular street people":* According to shelter providers, about 50 percent of Miami's homeless population are "regular street" persons who have been using emergency shelters for some time.

Approximately 645 persons in Miami are housed nightly in shelters and about 450 homeless individuals can be found outside each night, sleeping in cars, under bridges, in parks, etc. Another 521 homeless persons are estimated to be housed temporarily each week in public institutions, such as hospitals, jails, and alcohol detoxification programs.

Homelessness in Miami is caused by a number of factors, including:

- Migration of people from other parts of the country who have been attracted by the city's climate and prospects of finding employment.
- Immigration of legal and illegal refugees from the Caribbean.
- Unemployment created by various economic factors, including the lack of unskilled jobs.
- Deinstitutionalization of chronically mentally ill persons.

Health Needs

Since 1981, the City of Miami and surrounding Dade County have had a large number of new cases of tuberculosis, many of which are found among displaced individuals. Service providers, while unable to provide specific data on the health problems of their homeless clients, indicate that respiratory problems are common among Miami's homeless population. "Many homeless have been heavy smokers for many years, have low resistance to colds, and dress inappropriately for hot and cold weather. Therefore, "the applicant feels," there would be a high incidence of upper respiratory ailments such as pneumonia, pleurisy, lung cancer and emphysema" among the homeless. Based on in-depth studies of medical problems of homeless persons in other metropolitan areas, it is believed that the homeless in Miami would also tend to suffer from hypertension, diabetes mellitus, trauma and various dermatitis cases. In addition to dermatitis problems prevalent among the homeless in other cities, however, Miami's homeless are specially predisposed to infections caused by mosquito bites and various fungi, specifically in the hotter months between May and October. After being scratched repeatedly and not cleaned regularly, mosquito bites can result in serious infections. Because they often do not have adequate protection from the elements, homeless persons are especially prone to having fungi grow on their bodies.

Health Resources

The primary provider of health care to indigent persons in Miami is the Jackson Memorial Hospital. All the services offered at this public institution are available to all patients regardless of their ability to pay. The Veterans' Administration Hospital also provides a full range of services to indigent persons who are veterans of the Armed Services. In addition, there are two federally-funded and one county-funded health care center in the city of Miami whose services are available to homeless and other indigent individuals. There are also two mental health centers, one of which provides inpatient services. Both programs also provide substance abuse treatment. Although the services provided at these facilities are available to them, homeless persons generally do not receive the medical assistance they need.

MILWAUKEE

Demographics

Data on Milwaukee's homeless result from a six-month shelter study and information received from an emergency shelter hotline. The application acknowledges the limitations of these data insofar as they represent individuals who had access to or sought assistance.

It is estimated that 6,500 people were homeless in Milwaukee at some time in 1983. Shelter data indicate single homeless have different characteristics than adults in family shelters.

Not surprisingly, adults in family shelters reported problems of domestic violence more frequently (68%) than those in single shelters. Mental illness, which was identified by 38 percent of singles was reported by only 10 percent of family shelter users.

Reasons for Homelessness

Factors contributing to homelessness in Milwaukee include those which relate to homelessness of the chronic homeless and to the "new poor." Economic factors such as high unemployment, declining number of jobs, and movement away from a labor intensive economy, are significant. The limited availability of low cost housing is another factor; also important is the inability of local and state governments to make up for recent federal cutbacks in social programs. Deinstitutionalization coupled with limited resources to serve the needs of those relocated to the community presents problems associated with homelessness, too. The applicant coalition estimates 7,200 to 9,600 chronically mentally ill are in Milwaukee County, with the highest concentration found on the project's target area. Other factors tied to homelessness are: domestic violence; eviction; substandard housing; and long-term conflict.

Health Needs

Though data are limited, the combination of shelter operators' estimates plus a survey reveal the broad parameters of Milwaukee's homeless health needs. Shelter directors listed the following as most frequently experienced health problems of shelter clients: seizure disorders; skin disorders; respiratory ailments; minor trauma; alcohol toxicity; infectious diseases; and mental health problems. Among chronic problems were: mental illness; lung and respiratory disorders; anemia and malnutrition;

hypertension; alcoholism and other drug abuse; dental problems; diabetes; and epilepsy.

	TOTAL	IN FAMILY SHELTERS	IN SINGLES SHELTERS
Adults in Shelter	1,750 (100.0%)	636 (36.3%)	1,064 (60.7%)
Sex:			
Male	988 (56.5)	47 (7.4)	941 (84.5)
Female	762 (43.5)	589 (92.6)	173 (15.5)
Race:			
White	862 (49.3)	270 (42.5)	592 (55.6)
Black	701 (40.1)	278 (43.7)	423 (39.8)
Native American	46 (2.6)	13 (2.0)	33 (3.1)
Hispanic	104 (5.9)	52 (8.2)	52 (4.9)
Other	16 (.9)	8 (1.2)	8 (.3)
Average Age	34	33	29
Marital Status			
Single	834 (47.7)	159 (25.0)	676 (63.5)
Married	344 (19.7)	260 (42.3)	75 (7.0)
Divorced	252 (14.4)	33 (5.7)	219 (20.6)
Separated	92 (5.3)	20 (3.1)	72 (6.8)
Widowed	43 (2.5)	4 (0.6)	39 (3.7)
Missing Data	185 (10.6)	—	—
Income			
No income	1,017 (58.1)	246 (38.7)	771 (72.5)
Average income of those w/income		\$400	\$200
Education			
Elementary	262 (15.0)	40 (6.3)	222 (20.9)
High School/GED	480 (27.4)	122 (19.2)	358 (33.6)
4 yr. college/trade school	136 (7.8)	8 (1.3)	128 (12.0)
Graduate school	23 (2.6)	0	23 (2.2)
Missing data	857 (49.0)	—	—
Work History			
No prior work history	60 (3.4)	1 (0.2)	59 (5.5)
Work at home	13 (0.7)	6 (0.9)	7 (0.7)
Unskilled labor	535 (30.6)	8 (1.3)	527 (49.5)
Skilled labor	237 (13.5)	14 (2.2)	223 (21.0)
Professional	28 (1.6)	5 (0.8)	23 (2.2)
Missing data	477 (50.1)	—	—

Health Resources

Three neighborhood health centers serving low income and indigent people are present in the project target area. The number of homeless who actually use the services is not known. Several major hospitals also

are present in the area. Although law requires that patients with emergent conditions be treated regardless of ability to pay, patients whose condition is not considered an emergency are not likely to be admitted. Hospitals are similarly unwilling to accept patients unable to pay for care in out-patient settings.

Two facilities are singled out by the applicant coalition as examples of institutions that do accept the indigent. One, St. Anthony Hospital, treats such clients on an in-patient and out-patient basis. It also administers a nurse clinic at a soup kitchen. Though not part of the target area, the Milwaukee County Medical Complex accepts patients who are indigent; a homeless person could theoretically travel to the Complex and receive care. However, the Center's downtown branch has closed and travel to the main facility is a distant trip of several miles from the downtown area frequented by homeless people.

Barriers to Care

The basic problem identified relative to obtaining care by Milwaukee's homeless is a lack of income and inability to pay. While families tend to be Medicaid eligible, this is not the case for single people, who often are categorically ineligible for Medicaid. Despite the availability of free care, access to it is another barrier homeless face. Hospitals located near areas where homeless people most frequently are found do not encourage use of these facilities by the homeless, as this group does not pay for care. Even emergency departments will transfer an indigent patient to the public hospital several miles away, if the patient does not present a true emergency. Neighborhood facilities which do serve the indigent and homeless do not encourage or reach out to this population. Other barriers to care include reluctance on the part of the homeless to go through the sometimes lengthy procedural and bureaucratic steps that precede provision of free health care. Finally, for many homeless people, health care follows the need for food and shelter in the list of priorities that must be dealt with daily.

MINNEAPOLIS/ST. PAUL

Demographics

It is estimated that as many as 10,800 persons may be homeless in the Twin Cities today. Another 1,200 persons, most of them mentally ill and/or chemically dependent, are currently housed in marginal living conditions and at high risk of becoming homeless. In 1983, the Mayor's Housing Office in St. Paul alone received about 2,500 requests for emergency housing. Local shelters for battered women received over 3,360 requests for assistance which they were unable to accommodate. Approximately 2,490 requests for temporary housing assistance were received by the Greater Minneapolis United Way.

Persons who are homeless in the Twin Cities have been categorized into one or more of the following subgroups. (Where given, the proportionate size of the subgroups is estimated from information gathered from surveys of emergency shelter users).

- *Chronic substance abusers:* (47% of the homeless persons interviewed in Minneapolis and 30% in St. Paul consider themselves chemically dependent). Many of these individuals, who tend to be alcoholics, also have emotional or mental health problems and limited family ties.
- *Chronic mentally ill:* (25% of the homeless persons interviewed in Minneapolis and 32% in St. Paul have received mental health services). These persons tend to have a history of repeated or long-term hospitalization; many have a need for psycho-tropic medications. Often, they resist involvement with formal social services or medical institutions.
- *Chronic unemployed:* 49% of those interviewed in Minneapolis and 51% in St. Paul had been unemployed for more than two years.
- *Persons evicted and/or with no utilities:* These people tend to be victims of the changing economy. They often have exhausted all their financial resources or benefits and may have come to the area seeking employment.
- *Victims of domestic violence:* These individuals, most of whom are women and children, have fled abusive domestic situations and are often without financial or family resources.
- *Runaway youths:* These adolescents, who have run away or have

been cast out of their homes, are often the victims of physical or sexual abuse and have no or limited financial resources.

The homeless in the Twin Cities also include persons discharged from state mental health institutions, ex-offenders recently released from incarceration, migrant workers who have lost their jobs and are seeking employment, and indigent persons who have become victims of disasters, such as fire.

Reasons for Homelessness

According to the Twin Cities Health Care for the Homeless Coalition, the principal causes for homelessness in St. Paul and Minneapolis include lack of housing affordable by low-income people, increasing incidences of poverty, and the high cost of basic necessities, such as shelter and utilities. There has also been an influx of people from other areas of the country who have been attracted by the cities' relatively low unemployment rate. Many of them, however, lack the resources to sustain them while they look for work. Subsequently, these transients become temporarily homeless. Other major reasons for the problem of homelessness are chronic mental illness and alcoholism.

Health Needs

Major health problems associated with the homeless population seen in emergency shelters and drop-in shelters in Minneapolis and St. Paul include chemical dependency, mental illness and a combination of chronic conditions. The health problems on the next page were reported by respondents to surveys conducted at shelters in Hennepin County and St. Paul in 1984.

Screening conducted through the Women, Infant Children (WIC) Supplemental Food Program revealed the following information about major health problems faced by homeless women and children housed at the St. Paul YWCA shelter: 85 percent of the persons screened had three or more major diet problems; 43 percent were overweight; 40 percent had elevated zep's which indicated possible undetected anemia; 11 percent were anemic. The majority had inadequate dietary intake. Pregnant women at the shelter were receiving inadequate prenatal care; only one of three pregnant women had received prenatal care and one of them had gained only seven pounds in her seven months of pregnancy. A case of untreated sexually transmitted disease was diagnosed in one of the homeless pregnant women.

Health problems commonly observed in a St. Paul drop-in center include upper respiratory infections, ear infections (frequently with ruptured ear drums), sexually transmitted diseases, scabies and lice, burns, localized infections, fever of undetermined origin, seizures, and heart complaints.

	Henn. Co. N = 68 Percent	St. Paul N = 53 Percent
• Responded "Yes" or "Don't Know" when asked if they consider themselves to be chemically dependent.	47.0	30.2
• Of the above, those who indicated that alcohol is the chemical with which they have the most problem.	93.7	62.5
• Have been admitted to detoxification.	45.6	43.4
• Have been in a residential alcohol or drug treatment center.	45.6	24.5
• Have been in jail, workhouse or prison because of something done when drunk or on drugs.	50.0	34.0
• Have chronic health problems.	38.2	43.4
• Are receiving care for chronic health problems.	23.5	24.5
• Are on medication for physical health problems.	16.2	20.8
• Need dental treatment.	63.2	54.7
• Have received mental health services.	25.0	32.1
• Have been in a state facility for mental health reasons.	10.3	9.4
• Are currently seeing a counselor or doctor for emotional or nervous problems.	11.8	7.5

Health Resources/St. Paul

Although homeless people are eligible to receive a number of health care services available to all indigent persons in St. Paul, various factors prevent them from accessing those services. For example, there are six

community clinics located in the city, four of which provide general primary care services and charge a fee based on the clients' ability to pay. None of the clinics, however, are located within walking distance of the area where most of the homeless congregate.

St. Paul-Ramsey Medical Center offers medical and psychiatric services to all individuals seeking assistance. However, it is believed that the size and complexity of this institution may intimidate and discourage homeless persons from using the services.

Some efforts have been made by local and private agencies to provide health care services designed specifically to help meet the needs of homeless persons. However, these efforts are often limited by lack of resources. For example, dental students, supervised by volunteer physicians and dentists provide services to homeless persons at the St. Paul Union Gospel Mission. Usually, the medical services are offered every other Thursday evening and the dental clinic is open twice a week. The availability of volunteers to provide these services, however, fluctuates significantly depending on the University's schedule. Several community clinics and the two public health agencies in St. Paul provided staff to a health clinic at the Dorothy Day Drop-in Center two mornings a week. This effort, however, was terminated in February, 1984 because of lack of funds. Also, some mental health and medical care has been provided at the women's shelter by the Ramsey County Public Health Department's Nursing Services, the St. Paul Division of Public Health, and the St. Paul/Ramsey County Nutrition Program. Due to limited staff time, these agencies have been able to provide only periodic consultation and screening. Additional reductions in staffing are expected to further reduce the agencies' abilities to provide these services.

Health Resources/Minneapolis

According to service providers who were recently surveyed regarding medical care available to the homeless in Minneapolis, many homeless individuals do not participate in public health care programs to which they are eligible, primarily because they do not want to deal with the programs' bureaucratic paperwork and other requirements. Homeless persons in need of health care are usually referred to the Hennepin County Medical Center's clinics or emergency room. As the Center's records do not reflect clients' residential status, it is not possible to determine to what extent homeless people are served by the Center.

The number of homeless persons served by Minneapolis' eight community clinics is also unknown. There are a number of factors which are believed to discourage the homeless from seeking the clinics' services. These include fees prospective clients not receiving medical or general assistance benefits are expected to pay, paperwork clients are expected to fill out, and the location of clinics which makes the clinics inaccessible to homeless persons who lack transportation.

An unknown number of homeless persons also use services at the Indian Health Board clinic. These individuals tend to be substance abusers and chronically unemployed and usually seek assistance only in cases of acute medical problems.

Some services also have been made available specifically for homeless persons in Minneapolis. For example, a volunteer nurse provides free blood pressure screening one afternoon a week at a drop-in center. Also, a physician provides physical examinations to men entering the Salvation Army's Habor Light Center which offers emergency lodging and chemical dependency treatment services to homeless persons. "Sick calls" also are available to any person staying in the facility. This service, however, has not been utilized fully by the Center's clients, suggesting to the applicant a need for greater efforts among the homeless.

A recent survey of approximately 300 individuals who have used the Center's emergency shelter services showed that 66 percent of the respondents had no medical or hospital insurance and that 50 percent had "no (public) assistance of any kind." Eighty-eight percent said they would prefer to receive medical assistance at the Habor Light Center rather than in a public hospital.

NASHVILLE

Demographics

On any given night, there may be as many as 1,400 individuals who are homeless in Nashville. The number of people who are homeless at least temporarily in the city throughout the year is much larger. Records of Nashville's two largest shelters show that over 10,000 individuals spent at least one night in those facilities in 1983. In 1984, an average of 475 people per night stayed at one of those shelters alone. Altogether, over 1,000 men, women, and children are given overnight shelter by local agencies such as the Salvation Army, the YMCA, and several churches. A census conducted in December, 1983 found 820 homeless persons in downtown Nashville, staying in places such as mission centers, bus stations and all-night coffee shops. A similar census conducted in March, 1983 found 836 homeless individuals in that area.

Who are Nashville's homeless? Some are transients from other parts of the country or from rural areas of Tennessee who have been drawn to "Music City" in search of jobs. Others are workers, temporarily displaced due to poor economic conditions. Many are mentally ill or substance users. Nashville's homeless population is estimated to consist primarily of men who are older, White, unattached, and unemployed. According to the surveys conducted of homeless people in the downtown area, about four-fifths are males; three-fourths are White. A large percentage are 60 years or older.

It should be noted, however, that data gathered thus far about Nashville's homeless do not include information about other groups, such as families and runaway youths, who are increasingly becoming part of this population. As in other cities, Nashville's homeless population is becoming more diverse and includes greater numbers of persons who do not fit the traditional description of homeless people.

Reasons for Homelessness

Nashville's central location makes it a convenient stop for many people traveling on the North-South route in search of jobs. Its relatively strong economy also attracts people from more depressed areas who have hopes of finding employment. Its "Music City" reputation stirs the aspirations of young musicians who hope to "make it" in the music business. Very often, however, these people's hopes for a better life do not materialize and they end up destitute, without any food or shelter.

Many of the city's homeless are long-time residents who have recently lost their jobs. While Nashville unemployment has been consistently below the national rate, there are over 14,000 people registered for work but unemployed. Many others have become "discouraged" and are not included in official statistics.

Furthermore, many of the people discharged from the two state mental health institutions and the five state adult correction institutions located near Nashville now find themselves in the streets, without adequate services. Domestic violence and family breakdown are also major causes of the problem of homelessness.

Health Needs

As is the case with the homeless population of other metropolitan areas, the health status of homeless people in Nashville is generally poor. They face an extensive range of health problems, many of which require continuous monitoring or treatment, something which is made particularly difficult by the nature of the homeless' lifestyle.

In an effort to understand better the health problems of the homeless, a team working under the auspices of the Council of Community Services' Homeless Coalition recently reviewed a sample of medical records from several sources which provide health care to homeless persons in Nashville. Respiratory problems were high on the list of the health problems identified. Other problems frequently mentioned were high blood pressure, alcoholism, and skin problems including wounds, foot irritations, and bug infestations. The information gathered did not include data on cancer, tuberculosis, and pregnancy, which are not dealt with at the sites where the data was collected.

In addition to the physical problems identified, mental health illness is reported to be prevalent among the homeless.

Health Resources and Barriers to Care

"Nashville is a city with a paradox," the applicant states. "It is home to two medical schools with teaching hospitals, over 4,300 beds of inpatient medical care, hundreds of physicians, a health maintenance organization, the headquarters of several investor-owned hospital organizations, an active voluntary health community, two neighborhood health centers, a Veterans' Administration facility, four community mental health centers, a regional psychiatric institute and a multitude of other health providers and agencies." Most of these services, however, are inaccessible to Nashville's homeless population who are in dire need of health care. Homeless people's inability to pay for services and their lack of transportation to reach those services are major factors preventing them from accessing needed assistance.

Some efforts have been made by local providers of health and social services in Nashville to help meet some of the medical needs of homeless

people. Physicians and nurses, for example, volunteer their time at the clinic located in the Union Mission. The clinic, which was established in early 1981 and has about 150 "patient encounters" per month, is open three afternoons a week. All patients are seen at no charge and medications are provided from samples which the clinic solicits. Two nurses practitioners from St. Thomas Hospital visit a soup kitchen once a week to provide diagnosis and treatment and to make referrals as needed assistance.

Approximately 100 homeless individuals are served each month through the Public Health Department's clinics. Another 30 homeless persons are served by the Department during their stay in local jails. Homeless individuals requiring additional services are most often referred to Nashville General Hospital which serves about 125 homeless persons every month, providing them with inpatient medical care. Under the Metro Certified Indigency Program, homeless persons can receive care at no cost if they "establish residency" at a local shelter. In addition, about 35 homeless persons are served each month at the Veterans' Administration Hospital.

By and large according to the Nashville Coalition for the Homeless, acute medical problems of homeless persons are dealt with in Nashville. There are, however, significant gaps of services for the chronically ill. There is also a "major problem of inadequate maintenance of records of all homeless ill persons, especially in regard to follow-up and referrals for treatment. In addition, the present system is without a central person or agency to advocate on behalf of the homeless and to (help them) acquire transportation and access to the services to which they are entitled."

NEWARK

Demographics

An estimated 8,500 people are thought to be homeless in Newark at any one time. "Over the past two years," the application states, "Newark has experienced an increasing population of homeless individuals, found in doorways, abandoned buildings, subways. There are also reports of 'squatters' in Newark Public Housing, families paying no rent and receiving no services."

Men and women and youth now make up Newark's homeless population. Below is a numerical breakdown of the city's homeless component groups:

SUBGROUP	NUMBER of HOMELESS	PERCENT of TOTAL	SOURCE-AGENCY
Abused men, women, and children	488	5.7	Shelter in Newark servicing abused individuals-Babyland Nursery-year ending 1983.
Streets/doorways, etc.	640	7.5	December 1982 to March 1983 study, "Homelessness in Newark: A report on the trailer people"-Salvation Army.
Eviction/loss of income.	1,500	43.5	Loss of housing due to inhabitable conditions or actions by governmental agencies-Newark Emergency Services for Families and Newark Relocation Assistance Program.
Runaways	791	9.3	Runaways and adolescents put out by their families-Newark Police Department-year ending 1983.
Hospital discharges	1,387	16.3	Hospital discharges reporting to social service agency and having no known address-American Rescue Workers-year ending 1983.
TOTAL	8,500		

Reasons for Homelessness

A major cause for homelessness in Newark is thought to be the unavailability of affordable housing. Other factors include deinstitutionalization, unemployment, evictions, loss of income, withdrawal of financial

support. The applicant coalition also identified health problems and physical disabilities as contributing to homelessness.

Health Needs

A study of more than 400 people who stayed in an overnight shelter set up in a trailer showed more than half had been treated in a hospital or clinic for medical condition and/or drug/alcohol dependency. Other medical conditions reported in the study were epilepsy, tuberculosis, blindness and deafness.

Health Resources

Health services in Newark include a mix of public and private resources. The applicant states that the delivery system is fragmented and sites are scattered. While the range of available services appears to include all health needs of homeless individuals, there is not a service system nor facility that serves homeless exclusively.

Barriers to Care

The major barrier to receipt of health care by homeless people in Newark is absence of sufficient knowledge about health resources. Other problems include access, which is limited as a result of the "scattered" placement of health resources, limited ability to pay for health services, and the lack of a central agency to coordinate and monitor provision of care for the homeless.

A final barrier to care appears to be a refusal or inability to accept the frustrating conditions under which homeless and low income people obtain health care. States the application, "The homeless in Newark may be desperate, and yet dignified in their desperation. Some would rather go hungry or go without needed health care than endure the ignominy of standing in line for food or sit waiting in over-crowded health facilities."

NEW ORLEANS

Demographics

The Mayor's Division of Human Resources estimates that about 4,000 people in New Orleans are homeless. Included in this group are the traditional and "new" homeless.

The local Travellers' Aid Society has broken the homeless population down into the following subgroups, which are not mutually exclusive:

- *Traditional, "skid row," 30%:* The majority are males, aged 40-50. Many are alcoholic and present long term health problems.
- *Recently unemployed, 30%:* This is a temporary class of homeless. Many have families.
- *Deinstitutionalized, 15%.*
- *Runaways, 5%:* Teenagers and young adults who are school drop-outs, depressed, isolated from families and are attracted to the streets of New Orleans, its party atmosphere and French Quarter life. Often these young people are drawn into a subculture of prostitution and drugs. They usually find somewhere to stay, leading to a relatively low level of apparent runaways while the true number is higher. They have little knowledge of the health care services available to them.
- *"Bag ladies", 5%:* Females in their late 30s, early 40s.
- *Mentally disturbed, 5%:* Individuals who have never been institutionalized whose psychiatric problems isolate them from the mainstream.
- *Temporary homeless, 5%:* Abused spouses and children who are evicted from their homes.
- *Stranded "roustabout," 5%:* Individuals at the lower strata of the economic scale who come to New Orleans looking for marginal work and do not find any.

Reasons for Homelessness

A number of factors contribute to homelessness in this city. Included are subtropical climate, cuts in state and city social programs, an unemployment rate of 8.5 percent despite the then-operational World's Fair, deinstitutionalization and evictions.

Health Needs

According to health and social service providers for the homeless, health problems include: tuberculosis; hypertension; dermatologic problems; alcoholism; drug abuse; nervous disorders; gynecological problems; hepatitis; eye problems; respiratory problems; depression and other mental problems. Homeless youth in particular have a high percentage of venereal disease, malnutrition, and both physical and psychological abuse problems.

Health Resources

The major provider of care for the homeless is the Charity Hospital, funded by the State of Louisiana. Both inpatient and ambulatory care are provided for indigent people. In a two-month review of patients seeking care, 432 of 20,011 were identified as homeless. Other providers of care include a VA hospital and a clinic funded by the city with assistance from the state and federal governments. The clinic received referrals from Charity Hospital, area boarding homes and institutions for young adults, and walk-ins. The city health department also administers a TB clinic which, in 1983, identified 11 percent of its active TB cases among homeless.

Mental health facilities funded by the State and federal government are scattered around Greater New Orleans. About one-fourth of individuals served in these facilities are thought to be homeless.

Barriers to Care

The application states: "The homeless face many obstacles to medical care. They lack finances and hospitalization insurance to pay for health care in the private sector. By their appearance, very often they are shunned and denied local access to and treatment of health care. Those public hospitals designated to care for the indigent are large bureaucracies which make the homeless feel threatened, isolated, and frustrated; and thus many do not seek the care needed."

Another major problem which increases the number of homeless persons is the release of individuals from hospital care with no follow-up or continuity of care at many temporary shelters and on the streets. For hospital care the homeless rely primarily on Charity Hospital. It is the only state-owned general public hospital in the Greater New Orleans area. Charity Hospital receives many homeless walk-ins, referrals from boarding homes, missions, caregivers, police and the courts. Because the hospital has large numbers of indigent and accident patients along with bureaucracy of route sheets and admission forms, many homeless individuals let medical problems go unattended. Twenty percent or more of all patients seeking medical aid through the emergency room and 2.5 percent of walk-in clinic patients leave without treatment. According to

a recent Charity Hospital Report, three out of five homeless patients leave the emergency room before being seen by a physician.

Many homeless veterans with honorable discharges are eligible for various types of medical care and financial aid according to whether an injury is service related and whether the injury is permanent or total. Unfortunately, the federal bureaucracy requires that an individual provide proper identification and other important service related information. Many of the homeless do not seek care because of these requirements.

NEW YORK

Demographics

Where most cities report the number of homeless on an annual basis, New York estimates an average of 5,641 single persons per night are served in shelters. Homeless families include 10,186 families in the municipal system; with 6,695 individuals under 21 years of age. Not included in the above figures are single persons or families in private shelters or people who do not seek shelter care.

"There have been major changes in the demographic composition of the city's homeless population over the past two decades," the application states. "In the 1960s the typical homeless person was male, over 50 years old, White and alcoholic. Today, the majority are Black and Hispanic, with a higher occurrence of previous psychiatric hospitalization. Though still overwhelmingly male, this population has also recently witnessed a dramatic increase in the number of women-both as individuals and single heads of homeless families."

- *Age:* The mean age for public shelter users was 35.
- *Ethnicity:* Blacks and Hispanics represent 75% of men and over 60% of women in city operated shelters.
- *Geographic origins:* While the majority of current shelter users are long-term residents, 31% of new shelter users were not.
- *Usual residence:* Nearly 75% of clients entering city shelters for the first time reported that their "usual" previous residential setting was their own apartment or that of a friend or relative.
- *Employment history:* Sporadic or minimal work history was the common response given by shelter users when asked. A Human Resources Administration (HRA) study of long-term shelter residents revealed that some 30% interviewed had not worked at all in the past two years.
- *Disabilities:* Mental and physical disabilities are frequently experienced by shelter users.
- *Prison history:* Approximately one-half of male shelter users had prison records.

Reasons for Homelessness

Three major factors contributing to homelessness in New York are:

- *Decline in low income housing:* Major federal cut-backs in low income housing are credited with the marked decline in housing available to people with little income. The limited availability of construction loans available to the city in combination with lower federal support for low income subsidized housing and the conversion of former SRO and other low-rent units combine to limit seriously the possible places to live.
- *Decline of unskilled and semi-skilled jobs:* The shift of the local economy from manufacturing to service industries in combination with a high unemployment rate (ranging from 12% in 1976 to 9.2% in 1984) leads to a scarcity of low-skilled jobs.
- *Deinstitutionalization:* The applicant estimates that as many as 35,000 deinstitutionalized people may reside in New York State. Because community-based programs have not met the needs of this group, a sizeable number of them are now homeless.

Health Needs

The application states, "The homeless suffer from the same full range of health problems that affect the average individual plus an assortment of other problems either caused or exacerbated by a lifestyle that lacks adequate nutrition, shelter, clothing, and health services. For the homeless, relatively minor illnesses often take catastrophic tolls due to neglect; some diseases, such as tuberculosis, are life threatening despite recent advances in medical treatment." Furthermore, by compromising the immune system, the stress of homelessness increases the risk of infectious diseases.

General health problems are seen to include: acute (pneumonia, ulcerated or gangrenous limbs, etc); chronic (seizures, thiamine deficiency, venereal diseases, etc); incapacitating mental illness and a variety of lesser emotional disorders. All of these are exaggerated by some form of substance abuse, usually alcoholism.

Homeless children are more accident prone and evidence above-average hyperactivity and/or withdrawal, inadequate nutrition, and risk from lead poisoning.

Health Resources

Despite the availability of health services, homeless persons in New York, as in other cities, have experienced serious problems of access. A number of providers of services to the homeless have instituted on-site and/or formal linkage arrangements for medical services.

Medical care is guaranteed to all public shelter users. In addition to emergency care available to emergency cases, on-site medical clinics are

present in seven shelters. Primary care and referral for other services is available.

A survey by the Coalition for the Homeless revealed that about 10 percent of voluntary service organizations provide some sort of organized medical services to people served; over one-half of these organizations indicated desire to establish medical services under the auspices of the homeless program.

Barriers to Care

The applicant coalition states "the greatest barriers to providing health services to the homeless lie in the area of financial and geographic accessibility rather than in inadequacy of overall quality of services. In addition, stereotypes of homeless people held by providers in the health care system make these providers reluctant to serve the homeless."

OAKLAND

Demographics

It is estimated that approximately 3,000 homeless persons are homeless in Oakland today. About 800 of them are housed temporarily in shelters and hotels. However, the majority of the city's homeless, or approximately 1,600 individuals, are turned away each month from local shelters because of lack of space. Another 600 homeless persons are estimated to live regularly on the streets of the city—in parks, bus depots, automobiles, abandoned buildings and under freeways.

"No longer embodied by skid row transients who 20 years ago constituted the bulk of its ranks" officials of the Oakland Health Care for the Homeless Coalition indicate, "Oakland's homeless population reflects diversity: the 'new' homeless—evicted families and individuals, victims of domestic violence, elderly single people and those in transit without adequate resources for shelter—along with a new underclass of mentally disabled persons, now share the streets with hoboes, alcoholics, and drug abusers." The city's homeless population is believed to be comprised of three major subgroups:

- *Traditional homeless:* Persons who have traditionally resided in the vicinity of Oakland's tenderloin or skid row streets: "bag people", derelicts, and other chronically homeless individuals.
- *Deinstitutionalized individuals:* Persons released from state mental hospitals to the Oakland community.
- *"New homeless:"* Those whose life circumstances have been affected by external factors, such as unemployment, domestic violence, gentrification and its resulting shortage of low-cost housing, personal crises, and reductions in public benefits.

The table appearing on the next page highlights specific demographic information on Oakland's homeless population. The information was compiled from a number of local sources, including a study conducted by the United Way's Subcommittee on Emergency Shelter and reports prepared by the city and the country.

**PERCENT DISTRIBUTION OF OAKLAND'S HOMELESS POPULATION
BY SUBGROUP, RACE, AGE, AND GENDER**

N = 3,000

Percent Distribution

Subgroup		Race		Age		Gender	
Total	100	Total	100	Total	100	Total	100
Traditional	31	White	36	20	21	Male	57
Deinstitutionalized	23	Black	66	20-45	62	Female	43
New	46	Hispanic	8	46-65	14		
		Other	2	65	3		

Reasons for Homelessness

There are numerous factors which have contributed to the problem of homelessness in Oakland. They include:

- *High unemployment:* From 1980 to 1982, Oakland's unemployment rate rose from 7.3% to 12.7%. While unemployment decreased somewhat during 1984, it remains considerably above the prevailing rate for the State and the nation. In addition, the sustained high unemployment of the 1980's has forced many people permanently out of the job market.
- *Pronounced poverty:* According to the 1980 Census, 18.2% of Oakland's population lives in poverty and no less than 30.4% are economically disadvantaged.
- *Lack of available low-cost housing:* Over the past three years, rents in Oakland have increased by over 33% while the number of foreclosures doubled between 1981 and 1983.
- *Increase in domestic violence:* The local shelter for battered women, for example, reports that the number of crisis calls it receives climbed from an average of 200 per month in 1981 and 260 per month in 1982 to 450 per month in 1983.
- *Changes in State mental health policies:* From 1970 to 1984, admissions to California State hospitals from Alameda County—approximately one-third of whose population resides in Oakland—decreased 96%, from 3,430 to 150. However, the availability of appropriate mental health services in the community has also continued to decrease.
- *Oakland's favorable climate.*

Health Needs

As the application indicates, homeless persons experience many health problems that are related to extreme poverty, poor nutrition, and poor hygiene. Some of the common health complaints of the homeless include diseases of the skin, and problems with the respiratory, gastrointestinal,

and cardiovascular systems. While very little information has been collected to date to document the health care problems of Oakland's homeless population, 1980 statistics on the city's health planning areas 8 and 9, where the majority of the homeless live, show that these areas have the highest mortality rate in the city. According to those data, the most frequent causes of death, in rank order, are atherosclerosis, diabetes mellitus, influenza/pneumonia, liver disease, cerebrovascular diseases, accidents and heart problems.

Health Resources and Barriers to Care

In Oakland there is one large county hospital and two county clinics that provide medical care regardless of patients' ability to pay. In addition, there is a large children's hospital for pediatric care and five community-based clinics that provide care to the medically indigent. A multiplicity of barriers, however, prevent homeless persons in the city from receiving health care. According to a recent survey of individuals who use emergency shelters and meal sites, homeless persons generally do not know where to find financially accessible health care that is targeted to the medically indigent. Many of those interviewed were also unaware of their need for medical care due to inexperience with the health care system, their lack of medical knowledge, and/or mental incapacity. As a result, homeless persons often wait until they are very ill before seeking medical assistance.

In addition, homeless persons' inability to pay for services, their lack of transportation, as well as negative attitudes toward the homeless and bureaucratic requirements of the health system prevent homeless people from receiving services they need and which are available in the community. Many of those services are provided by appointment only. As the applicant states, however, "if one does not know where he or she will be sleeping or eating, it becomes very difficult to call and plan a medical appointment."

Furthermore, homeless persons who are not already receiving public health benefits usually find it difficult to obtain Medi-Cal to pay for medical care or have to face long delays before receiving aid. Also, homeless persons, particularly the "hard core, chronically homeless individuals who exhibit difficult social behavior" or who are not clean at times face rejection from health care professionals.

OMAHA

Demographics

In any one year, it is estimated 5,700 to 6,000 homeless individuals are present in Omaha. These data are based on studies of the problem and observations by shelter operators and other caregivers. Approximately one-half of the homeless population is judged to be transient; the others are families who come to Omaha with limited or no financial resources or those who have been forced to give up housing in the area. It is estimated that a minimum of 550 of the homeless population had been hospitalized for mental illness during 1983.

According to shelter providers and others, chronic unemployment is typical for the majority of homeless. Other characteristics are: mentally ill/developmentally disabled; deinstitutionalized; families with insufficient incomes.

Reasons for Homelessness

Homelessness in Omaha is related to the following factors:

- Reduced employment opportunities in laborer classifications, specifically from packing industry reductions, construction industry depression, economic problems in the farming industry, etc.
- Weather related economic problems such as extreme utility cost and poor housing quality regarding weatherization.
- Insufficient income to meet rental housing costs (averaging 10% per year), utility costs, and the other survival costs.
- Geographic location that brings many travelling families and individuals through the metropolitan area.
- Abused mothers with children who are temporarily displaced from their homes.

Health Needs

While confirmed data do not yet exist relative to the health problems of Omaha's homeless, a number of health problems are assumed to be present in the homeless population. These include: nutrition; exposure; trauma; acute infections; chronic diseases; poor visual acuity; mental health disorders; hygiene; and dental.

Health Resources

No health care facility exists to serve the needs of the homeless exclusively. However, a range of services, providers and financing sources are present in the Omaha SMSA that in combination offer the services needed.

Barriers to Care

The lack of coordination among social service advocacy systems is thought to be the foremost barrier to receipt of health care by the homeless. Additional barriers include the difficulties in utilizing transportation and the relative low prioritization level of health vs food, shelter, clothing or drug/alcohol dependency.

Other problems include lack of public awareness about the extent and severity of homelessness and failure to qualify for the county indigent care system because of transience or excessive personal resources.

PHILADELPHIA

Demographics

According to the applicant, the Philadelphia Health Care for the Homeless Coalition, "homelessness, particularly intermittent or marginal homelessness, is a widespread phenomena in Philadelphia." The Coalition estimates that between 10,000 and 13,000 individuals are currently homeless in the city. This figure includes people living in housing conditions so marginal in nature (i.e., friends' homes, extremely dilapidated housing, inappropriate treatment facilities, etc.) that they are continually at risk of becoming homeless. Philadelphia's homeless population, as those of other cities, is very heterogeneous. It is comprised of several subgroups which include:

- *Economically deprived people:* Estimates of the number of individuals in this group range from 8,000 to 11,000. They include chronically or temporarily unemployed or underemployed persons who cannot afford housing, transients, and single parents with children. While some of them may live on the street or in shelters for long periods of time, others, particularly women and families, survive by alternating between friends' homes, abandoned or very substandard housing, and shelter facilities.
- *Chronically mentally ill individuals:* There are between 900 and 1,600 chronically mentally ill homeless persons in Philadelphia. About two-thirds of this group is believed to be made up of older, more passive, chronically mentally ill persons who have spent considerable time in mental health institutions. The others are generally younger, more aggressive individuals who typically have repeated, short-term contact with mental health and social services and criminal authorities.
- *Chronic alcoholics and substance abusers:* Estimates of the number of persons who comprise this group, most of whom are alcoholics, range from 1,200 to 1,500. This group overlaps to some extent with the "economically deprived."

Reasons for Homelessness

The major causes of homelessness in Philadelphia are varied and complex. Among them are:

- Recent reductions in state and federal income support programs.

coupled with requirements of public assistance programs that recipients maintain a permanent address.

- Lack of appropriate community treatment and housing facilities for chronically mentally ill persons.
- A severe shortage of low-income housing (approximately 12,000 individuals and families are on the Philadelphia Housing Authority's waiting list for public housing units).
- Poor economic conditions and the resulting dislocation of many previously employed workers, chronic unemployment and under-employment.
- A severe shortage of beds at nursing homes and other alternative long-term care facilities for mentally or physically frail elderly persons.

Health Needs

Specific information on the health problems of homeless persons in Philadelphia concerns mostly chronic alcoholics (the "Skid Row" population) for whom services have long been established in the city. According to information provided by the Diagnostic and Rehabilitation Center, which has over 20 years of experience in dealing with this subgroup of the homeless population, major problems affecting chronic alcoholic homeless persons include tuberculosis, obstructive pulmonary diseases, heart conditions, diabetes, venereal diseases, and a variety of skin and foot problems.

Information about other groups of homeless people in Philadelphia has been largely extrapolated from literature available on common health problems of the homeless in other cities. Medical conditions identified include respiratory problems such as tuberculosis, pneumonia, emphysema and chronic bronchitis; various communicable diseases, such as influenza, diphtheria, and venereal disease; the effects of trauma resulting from accidents or violent attacks; seizure disorders; and, dermatological problems including scabies and lice infestations. Chronic mental illness is also a very prevalent problem among the homeless.

Health Resources

Health services specifically designed to meet the needs of homeless persons are "largely underdeveloped in Philadelphia," the Coalition indicates. One program which has been developed specifically for homeless persons, however, provides basic medical care and screening to individuals who use a drop-in center which is funded by the city. Through an arrangement with the city's health department, non-emergency medical care is provided to these individuals at a public health center when needed. A psychiatric outreach team, operated by the Hall-Mercer Com-

munity Mental Health Center, visits the drop-in center three times a week.

Barriers to Care

As in other cities, Philadelphia's homeless face tremendous difficulties in accessing health care programs available to the indigent individuals. For example, a major source of health care for indigent medically uninsured people in the city is the Family Medical Care (FMC) Program, established in 1976 in response to the closing of Philadelphia's only public hospital. The program is operated by the health department in eight health centers located throughout the city which provide comprehensive out-patient services regardless of clients' ability to pay. The health department also contracts with four hospitals to provide patients enrolled in the FMC Program with ambulatory specialty consultations and emergency care. Factors which prevent homeless persons from utilizing the FMC Program include the:

- Reluctance or inability of homeless individuals to negotiate with the FMC Program on their own, (i.e., interacting with FMC Center clerical staff, communicating their needs to medical personnel, and following through with treatment or referrals).
- Unfamiliarity of FMC Program staff in dealing with the homeless, particularly chronic "street people."
- Unfamiliarity of private services providers with the FMC Program and their inability, due to lack of staff, to assist homeless clients in entering the program.

PHOENIX

Demographics

In the last two years, two studies have been conducted in Phoenix in an effort to examine the problem of homelessness in the city and to develop a profile of the local homeless population. According to these studies, between 2,500 and 3,000 persons are estimated to be homeless in Phoenix at any given time. The average homeless person in Phoenix is a White male, approximately 36 years of age, with a high school education, who arrived in Arizona during the last six months looking for a job. The studies also provided information which confirms that Phoenix's homeless population, as in other cities, is very heterogeneous:

- 87% of the homeless are men.
- 61% are White, 17% Hispanic, 12% Native Americans, and 9% are Black.
- 54% are between 20 and 39 years of age, 35% are between 40 and 59, 9% are over 60, and 3% are less than 20 years old.

Forty percent of the homeless were described as "employable." Of the 60 percent to be found "unemployable," 20 percent were chronically mentally ill, another 20 percent were chronic alcoholics, 5 percent were "socially maladjusted," 5 percent were described as "worn-out workers" and 10 percent had limiting physical disabilities. The studies also found that those categorized as "unemployable" generally had more health problems and poorer overall health than the "employable" homeless individuals.

Reasons for Homelessness

Economic factors are considered to be the major cause of homelessness in Phoenix. According to the two recent surveys on the problem in the city, approximately 50 percent of the homeless had relocated to Phoenix to find jobs. Although its unemployment rate during the recent economic recession equalled the national average, Phoenix has a national reputation for having a rich job market. Thus, people migrate to Phoenix from all over to secure jobs. They come from the Northeast and Midwest where unemployment rates are higher; from Mexico, to work in agricultural jobs; from Indian reservations; and, from rural Arizona mining towns affected by the copper strikes. Jobs in Phoenix, however, are not plentiful and many of the jobs that are available require advanced or specialized

training. Once in Phoenix, many of these people exhaust all their resources before they can find a job, thus becoming destitute.

The two other major factors which have contributed to homelessness in Phoenix—deinstitutionalization and lack of low-cost housing—are interrelated. The local and national trend to deinstitutionalize the chronically mentally ill, while a well-intended movement, did not provide alternatives either to treatment or to housing for these individuals, according to the applicant. Once in the community, deinstitutionalized persons often live in the same type of housing inhabited by many older single individuals, migrant workers, and physically-disabled persons—single-room-occupancy hotels and other low-cost housing in downtown Phoenix. In the past five years, however, many of these housing units have been demolished. Unable to find alternative low-cost housing, significant numbers of mentally ill and other poor people have become homeless in the city.

Health Needs

According to medical statistics of the Maricopa County Department of Health the major physical health problems of homeless persons who seek medical services are:

- Diseases of the respiratory system such as upper respiratory infection, pneumonia, influenza, chronic bronchitis, and chronic obstructive and pulmonary disease (36%).
- Skin diseases (skin infections and infestations, acne, dermatitis, urticaria, etc.) (13%).
- Injuries, including broken bones, bruises, cuts, lacerations, etc. (9%).
- Diseases of the nervous system, musculoskeletal system, and digestive system (7% each).
- Circulatory infections and mental disorders (7%).
- All other problems comprise 10%, while only 4% of the homeless are categorized as having no disease or health problem.

Information obtained by shelter in-take workers from interviews with homeless people show discrepancies between health problems reported by homeless persons and problems for which care is sought. These discrepancies suggest to the applicant that there is an "educational barrier" regarding health services for the homeless: the homeless generally have a low level of "education" about types of symptoms to look for, and health care providers need to know more about the special problems of the homeless population.

Health Resources

The Maricopa County Department of Health Services and the St.

Vincent de Paul Society have been the two major sources of physical health care for the homeless population. The Maricopa County Department of Health Services, through its two major divisions, the Maricopa Health Department and Maricopa Medical Center, has traditionally provided health care to the low income, indigent populations which include many homeless individuals. With the increase in number of homeless persons and a greater concentration in homeless shelters in Phoenix, the Health Department began assigning public health nurses to the shelters to screen and evaluate homeless persons who voluntarily sought treatment. Those individuals requiring the services of a physician were referred to a primary care center or, if there was need for immediate attention, to an urgent care facility.

Nursing staff has been available at The Salvation Army "overflow" shelter and The Salvation Army Family Service Center three times per week, and at The Emergency Shelter five nights per week, Monday through Friday. In addition, staff from the Maricopa County Health Department's Bureau of Communicable Diseases have provided treatment for lice infestations, immunizations and skin tests for communicable diseases. Nursing staff has also been available to do evaluations of some homeless residents living in residential facilities.

The St. Vincent de Paul Society has operated a clinic on Monday and Wednesday mornings. Staff from the Maricopa County Health Department work closely with the St. Vincent de Paul Clinic in attempting to identify and treat the health problems of the homeless.

Behavioral health counseling is currently available through two programs offered by Phoenix South Community Health Center (Phoenix South) and through the local Alcoholism Reception Center (LARC). Phoenix South's programs provide general counseling, advocacy and social services to all residents of the Emergency Shelter and the "overflow" shelter. Specific services are also offered to the chronically mentally ill living in these shelters. LARC provides outreach and detoxification services to the alcoholics on the streets.

Advocates for the Disabled provides counseling and advocacy for all disabled, elderly, and chronically mentally ill persons eligible for entitlements. These services are also provided directly out of the Emergency Shelter.

Barriers to Care

Homeless people's lack of information about available medical services and denial of health problems are considered to be major obstacles which prevent them from receiving care. Sixty-five percent of the homeless persons interviewed in a recent study on the health status of homeless persons in Phoenix indicated they had experienced some health problems in the past year. Many of them, however, had initially denied needing medical care and it was only after some probing from the interviewers

that they admitted to having health problems. Of these people, approximately 40 percent indicated they had not sought medical services. The major reasons given were lack of knowledge of low or no-cost health services available in the community. Sixty percent of the respondents, for example, were not aware of the existence of the Arizona Health Care Cost Containment System (AHCCS), Arizona's substitute for Medicare.

AHCCS, however, currently has many barriers which are impediments to receipt of services by the homeless. In addition to the homeless' lack of knowledge about the program, barriers include the inability of many homeless persons to apply for AHCCS benefits and fill out the necessary forms, and lack of transportation to reach participating doctors or "plans" that often are not located close to the area where the homeless gather.

PORTLAND

Demographics

There are five subgroups of homeless in the city of Portland which at any given time are conservatively estimated to total some 4,500 people. Because of the high degree of transiency which occurs in relation to the need for migrant farm workers in nearby valleys, Portland service providers estimate approximately 8,000-10,000 homeless individuals are present in the city of Portland over the course of a year. The subgroups of homeless in Portland have been categorized as follows:

- *The chronic or traditional homeless:* The men and women who have been traditionally called "transients" or "derelicts," and who seek shelter in cheap hotels, overnight shelters, and under bridges. Estimates of their numbers in Portland range from 2,000-3,000 (44%-66%). Some of these women also have young children with health problems. One hundred and fifty to two hundred children under the age of ten may be found in Burnside area hotels during one year.
- *The deinstitutionalized:* Men and women released from state and mental hospitals who receive inadequate follow-up care and are unable to remain in stable living situations, drifting in and out of hotels and rooming houses. Between 750 and 1,000 people in Portland may be in this situation (16%-22%).
- *The new poor:* With worsening economic conditions, many people who had been in stable situations have been "dishoused." They move frequently, often moving in their cars with their young children. No reliable estimates of their numbers exist. It is believed many are living in outlying areas of the city and county, and travel to the downtown area for services.
- *Street youth:* Adolescents, frequently sexually abused, who are runaways and "throwaways" have taken to the streets of Portland, many of whom are involved in prostitution and have alcohol and drug abuse problems. Outside In, a community-based clinic and counseling center, estimates 300-600 such individuals are homeless, sometimes moving as groups into single motel rooms during the winter months, and as economic resources allow.
- *Battered women:* A Portland shelter for this population estimates about 100 such women remain homeless, i.e., in shelters and in a

state of transition for a period of two weeks or longer at any given time. Many of these women repeatedly move in and out of their homes and back into the shelters. Treatment for traumatic injuries and mental health counseling services are particularly needed by these women, and many have no third-party coverage for their care.

Reasons for Homelessness

The preponderance of Portland's homeless congregate in the city's Burnside area. It includes the area generally known to city residents as the "Skid Road" of Portland (once a wooden road upon which loggers rolled their timber to the river). The area is characterized by a collection of taverns, night shelters and single room occupancy hotels (there are approximately 3,000 SRO rooms in the area), second-hand stores, cafes, groceries, missions and service centers. Thirty-two percent of the 3,300 permanent residents of the central city (including the Burnside area) have incomes below the poverty level. In the core Burnside census tracts, nearly 60 percent of all residents are below the poverty level.

Since the end of the 19th century, the Burnside district has served as a haven for transients. Portland's temperate climate means work for migrants eight months of the year. Once these workers return to Portland in the coldest months, they, along with the chronic alcoholics and other chronic homeless individuals, are for the most part ineligible for Medicaid and other general assistance under state and local public assistance programs. In recent years, this traditionally homeless group has been joined by four other subgroups of homeless in Portland: the deinstitutionalized, the new poor, battered women, and street youth.

Health Needs

Health problems which are endemic to the homeless population in Portland are chronic alcoholism, chronic mental illness, and severe personality disorders. Four years ago, of 2,300 persons then residing in or frequenting the Burnside area of Portland, 1,900 were assessed by 21 social service agencies as having the symptoms of late stages of alcoholism and manifesting its most common symptoms of physical deterioration, loss of control, decrease in alcohol tolerance, malnutrition and social isolation. This situation has not improved since that survey was undertaken. Associated illness and diseases include cirrhosis of the liver, tuberculosis (30% of all TB patients in the county reside in this area, while the area accounts for only one percent of the county's total population), seizures, body parasites, and traumatic syndromes.

The homeless also suffer the same "routine" problems experienced by the general population, but experience more frequent chronic conditions resulting from exposure, poor nutrition, and general lack of care. Inadequate access to health care also results in debilitating and chronic condi-

tions such as untreated diabetes, seizure disorders and hypertension.

The most prevalent health problems experienced by street youth include sexually transmitted diseases, physical and mental problems resulting from sexual abuse, alcohol and drug abuse.

Homeless women are in special need of prenatal care, which is available on a limited basis to the medically needy in downtown Portland through the community health clinic, Outside In. An increasing number of homeless children are showing signs of mental disturbances.

Health Resources

A range of services exist in Portland funded by: the community; federal, state and local government; and, private sources. However, while these health services are available for use by homeless people, neither are they generally designed to serve this population, nor, in most instances are the homeless encouraged to utilize available, appropriate services.

Barriers to Care

There are two major barriers to the provision of adequate health care for the homeless. The first is the shortage of funding for care. Oregon's new medically needy program under Medicaid is confined to care for pregnant women. The second barrier is the absence of an organized system which coordinates the delivery of services and assures continuity of and accessibility to care at the level required (primary care, as opposed to unnecessary use of emergency rooms, and inadequate access to mental health and other needed specialty care).

ST. LOUIS

Demographics

According to a study conducted by the St. Louis Relocation Clearinghouse, a private agency that provides assistance to homeless persons, approximately 10,000 individuals were served by the city's 23 shelters in 1983. This represents a 43 percent increase over the 7,000 served in 1982. In addition, about 1,500 individuals were turned away from local shelters each month in 1983 because of lack of space. In the first quarter of 1984, the demand for emergency shelter increased by 40 percent over the same period in 1983. These figures do not include the many "undocumented" homeless in the city—those who do not seek emergency shelter.

St. Louis' homeless population is clearly heterogeneous in characteristics as well as in needs for services. At least three different homeless groups have been identified: 1) families made homeless through a number of reasons including domestic violence; 2) individuals recently discharged from mental health institutions; and 3) transients.

A study of 165 homeless men who regularly sleep outdoors in the St. Louis area and who generally do not seek emergency shelter revealed that all of the men interviewed were unemployed; 47 percent of them for six months or less. Forty-eight percent had been homeless for six months or less. Forty-one percent had been hospitalized in a mental health facility at some point and 70 percent of those with a history of hospitalization had been discharged immediately prior to becoming homeless. Most of the men, or 56 percent, were unskilled and had less than a high school education.

Information provided by operators of nine shelters regarding persons who requested their services during a seven-month period in 1980 showed that:

- Fifty-two percent of the 2,881 requests for assistance which the agencies received during that time were made by families headed by a single female parent with two or more minor children.
- Sixty-one percent of the people seeking shelter were residents of the City of St. Louis.
- Most of the people received public assistance or had no financial support.

Reasons for Homelessness

The St. Louis Health Care for the Homeless Coalition has identified the following as primary causes of the problem of homelessness in the city:

- Family instability which often results from factors associated with poverty (e.g., low public assistance levels, unemployment or underemployment) and spouse and child abuse.
- Deinstitutionalization policies which have resulted in the discharge of large numbers of former patients of mental health institutions without adequate supervision and support.
- Significant numbers of transient individuals and families who pass through St. Louis en route to other destinations and who become destitute when their resources are exhausted.

In addition, there are several other factors which affect the problem of homelessness in St. Louis. They include recent shifts in the city's population, increased unemployment and legal limits on the city's boundaries. A decline in St. Louis population, which reached a loss of approximately 21 percent between 1970 and 1980, has resulted in increases in the proportion of old and poor persons in the city. A related effect of this shift has been an increase in unemployment resulting from a decline in businesses and manufacturing jobs. These negative local trends were exacerbated by the national recession. Urban renewal projects for commercial development and the process of "gentrification" have also displaced many poor families and reduced the availability of housing for low-income people.

Also, the legal separation that exists between the City of St. Louis and St. Louis County prevents the city from expanding to more affluent surrounding areas. This creates a major problem for the city, which has a declining tax base and deteriorating properties, in addressing the growing economic and social problems of its population, including homeless people.

Health Needs

Common health problems of the homeless in St. Louis include most of the chronic illnesses found in the average adult population, i.e., hypertension, diabetes mellitus, obesity, depression and anxiety, and chronic obstructive pulmonary diseases with secondary complications. In addition, however, the homeless are at greater risk of peripheral vascular diseases, trauma, pulmonary tuberculosis, infestation, malnutrition, alcoholism and other substance abuse, hyperthermia, and dental disease. Physical and emotional injuries resulting from domestic violence, including both spouse and child abuse, are also major problems among homeless families. The need for prenatal and neonatal care have been identified as major problems by emergency shelter personnel.

Health Resources

Health care services currently available to the homeless in St. Louis include four ambulatory care centers, five primary care community health centers, St. Louis City Public Hospital, and several private hospitals.

In addition, Harbor House, a Salvation Army institution, operates a detoxification program which can accommodate 15 men. A similar program for women, also with approximately 15 beds, is operated at the St. Louis State Hospital.

Barriers to Care

While these services are available to all indigent persons, they are often inaccessible to the homeless. Various factors, including homeless people's lack of transportation and financial resources and their distrust of medical institutions, as well as negative attitudes towards the homeless found among the public and medical professionals, often prevent homeless persons from trying to obtain needed medical services.

SAN ANTONIO

Data provided by San Antonio reflect the number of homeless people who used shelters during the 1983-1984 winter. The total number of homeless people in this category falls somewhere between 10,111 and 15,331.

The following categories are thought to make up the city's homeless population:

- Street people who use social services occasionally and shelters not at all.
- Singles and families who are chronically unemployed and use shelters intermittently.
- Deinstitutionalized and other people released from jails or detox units.
- The situationally homeless, e.g., adolescent runaways, battered spouses, etc.
- People travelling in hopes of finding employment.
- People who cross the border from Mexico to join family members and are unable to locate employment or housing.

An informal survey of 139 individuals in line to gain admittance to a shelter suggested that 60 percent were Anglo, 15 percent Black, and 25 percent Brown, with a median age of 32 years. Fifty-seven percent reported that they had been in San Antonio less than one year. The majority (90%) were male and single (44%). While 38 percent said that they had been employed at their last job from one month to one year, with the main source of income being work for 70 percent. The income, however, was very limited, below \$1,000 for the full year reported by 52 percent; only nine percent said that they had an income over \$10,000 in the previous year.

Reasons for Homelessness

Poverty is one of the leading factors influencing homelessness. While San Antonio ranks third among cities for the percentage of female headed households living in poverty, the State of Texas ranks 49th for AFDC payments to these families.

The small number of public housing units, compounded by slow turnover rates, is another reason for homelessness. The current system, moreover, lacks any coordinated process to identify the wide range of housing needs and resources.

Finally, the application notes, San Antonio "is placed geographically so that it is on the railroad and highway lines moving both East/West and North/South. This means that there are a large number of transient persons that move across the Florida-Southern California route" to seek work or join families. Also, this location makes it the first major city reached from central Mexico, resulting in large numbers of illegal alien residents without means of support.

Health Needs

The study of 139 shelter seekers is the source of data regarding health needs of San Antonio's homeless. Sixty-eight percent indicated they had no problems with their health. However, 36 percent indicated that they had been hospitalized between 1976 and 1982 and 24 percent indicated hospitalization in 1983. Emergency care was the reason for hospitalization in 40 percent of the cases. Actual self-reported health problems are similar to those that appear for other cities.

Health Resources

San Antonio offers a full range of services that the homeless may use. However, the application states, "a major problem for the homeless relative to utilization of these services is access."

Barriers to Care

Chief among barriers to care is access to care. This includes the inability of the homeless to reach and pay for services and the reluctance of the provider community to attempt to make services accessible to this population.

SAN DIEGO

Demographics

A study requested by the City of San Diego estimates there are approximately 2,000 homeless individuals in the downtown area at any given time. This population is predominantly male (95%) and young (average age 32.8 years). Ethnic breakdowns are estimated to be 71 percent White, 23 percent Black, and six percent Hispanic. Most are single, without family support (93%). All were unemployed and existed by part-time employment, selling plasma on a weekly basis, and receiving charity through the shelters and free food facilities. Sixty-five percent are from outside the San Diego area. The average education is eleven years. Forty-four percent are veterans. The homeless are in San Diego to find work and to seek better weather conditions. Fifty-nine percent of the population have been in San Diego for less than one year. Over 60 percent indicated they had health problems. Forty-one percent of the population had been to a detoxification center for alcohol-related problems.

Women and children in the homeless population who are housed primarily in shelters are not statistically reflected in this survey, as it was directed at the homeless street population.

Reasons for Homelessness

The applicant coalition outlines the reasons for homelessness in San Diego as follows:

- *Economic:* Unemployment increases due to lay-off by major San Diego industries, decreased governmental services, chronic unemployment, reduced state assistance in unemployment compensation.
- *Geographic:* Mild climate, close proximity to Mexican border, redevelopment of downtown area, recent "clean-up" of city's canyons and freeway ramps so that homeless are pushed into the city.
- *Military population:* Discharged military personnel with marginal status on "appellate leave," ex-military returning to San Diego, V.A. Hospital veterans move to San Diego to receive medical care.
- *Attitudinal:* "Fortune Hunters"—myth in United States to move to San Diego, the land of milk and honey, people escaping from present situation.
- *Sociological:* Deinstitutionalized—mentally ill, elderly, post-hospitalized, chronic health and physical problems.

Health Needs

In a survey of San Diego's homeless, over 60 percent of the population reported a health problem of some kind. Only five percent reported that they were currently receiving treatment. Alcoholism is the number one health problem, with 28 percent of the population stating a concern related to this problem. This percentage compared to the number of homeless individuals taken to the city's detoxification center (41%) indicated alcohol is a major problem for San Diego's homeless. Injury, illness, and infection together are reported as problems by 30 percent of the population. Dental care and nutrition needs have also been identified as health problems of this population. These percentages show that the homeless population seems to be at high risk for both physical and psychological problems.

A major issue facing homeless people in San Diego is the lack of a health care clinic in the downtown area. In addition to the lack of a clinic downtown, it appears that the level of information disseminated concerning eligibility for medical coverage is inadequate. Even if this information were available to the homeless, the lack of permanent residence would eliminate this population from certain governmental services available. The lack of timely transportation to health care service sites is also a significant barrier to seeking needed services.

Health Resources

There are no health care services in the downtown area to serve the homeless population. What few services are available are provided through public health nurses and volunteer physicians using limited supplies and equipment. These services are provided in two of the three shelters located downtown, and only on an infrequent basis. Access to a health facility for treatment of chronic or acute health problems is not available, as there are no hospitals located in the service delivery area. When service is required, patients must be transported, which is cumbersome and time-consuming. There are limited mental health services in the service area and ongoing treatment requires transportation outside the proposed service area. Services for veterans are not available downtown and require transportation outside the proposed service area (30-60 minutes by bus).

Barriers to Care

Health care for San Diego's homeless is limited due to the barriers created by lack of adequate transportation, unfamiliarity with the services available, and the complex eligibility screening process required for many of these services. Most homeless persons find it too difficult to complete the eligibility process without the assistance of case workers.

SAN FRANCISCO

Demographics

It is not known how many people are actually homeless in San Francisco. Estimates of the city's homeless population range from a low of 3,000 to a high of 15,000. Whatever the exact number is, however, it is clearly evident that the problem has increased dramatically in recent years. Since December 1982, when the City's Shelter for the Homeless Program began, an average of 1,200 persons have been sheltered nightly. However, there are many more homeless persons in the city in addition to those who seek shelter. Although the city government has a policy of sheltering all who request it, many people are found sleeping in the streets of San Francisco.

Monthly surveys of persons using emergency shelters in San Francisco have revealed the following composite characteristics of this population:

- 78% of homeless people in the shelters are men; 52% are White, 28% Black, and 1% Hispanics. Native Americans account for 3% of the homeless population; Asians for 2%. The median age is 31.4 years.
- 33% have lived in San Francisco for less than three months; 17% for less than a year.
- 68% indicated having marketable skills; 71% reported holding a job for more than one year.
- 56% said they had completed their high education; 17% were college graduates.
- 29% have permanent or temporary physical disabilities; 12% admitted having mental problems. (The San Francisco Department of Public Health estimates, however, that the number of homeless persons who are mentally ill may exceed 40%).
- 18% reported some form of drug abuse; 37% reported some form of alcohol abuse. (The Health Department estimates, however, that the actual incidence of substance abuse may exceed 60%).

It should be noted that the surveys do not include information about homeless families or single adults being housed in hotels. In January, 1984, over 280 families with children, including many infants, were sheltered by the city in hotels.

Homeless youths also comprise a large segment of San Francisco's homeless population. A report released by the Mayor's Criminal Justice

Council in March, 1984 estimated that there are approximately 1,000 homeless adolescents in the city. They come from various racial and ethnic backgrounds and many are victims of physical and sexual abuse.

In addition, another large group of persons, many of whom rely on General Assistance (GA) for support, are considered to be "intermittently homeless." In 1983, 92,220 different individuals in San Francisco received GA. Their demographic characteristics and the inadequate levels of assistance they receive place this group at high risk of being homeless.

Reasons for Homelessness

There are a number of factors which have contributed to the recent dramatic increase in the number of homeless persons in San Francisco, they include:

- *Deinstitutionalization:* The number of state psychiatric hospital beds for severely mentally disturbed people in California declined from one bed for each 430 state residents in 1960 to one bed for each 4,800 state residents in 1983. Since residential treatment programs are not sufficiently available in the community due to fiscal constraints, many mentally ill persons do not receive treatment and have become homeless.
- *Insufficient housing for low-income people:* As a result of "urban renewal" much of the housing previously available to the economically disadvantaged has been razed or converted to other uses.
- *Unemployment/migration from other cities:* Increases in the local unemployment rate have forced many into temporary or permanent poverty. Similar increases in unemployment elsewhere in the nation have led many to come to San Francisco, where they are often unable to find employment.

Health Needs

The homeless in San Francisco suffer a broad range of serious medical and psychiatric problems. A survey of patients admitted to San Francisco General Hospital during the first quarter of 1983 revealed that at least 318 patients, who accounted for 7.7 percent of the admissions, were homeless. Fifty-eight percent of them were admitted for medical or surgical problems and 42 percent were admitted for psychiatric problems. Medical and surgical problems of the homeless that necessitated admission included pneumonia, cellulitis, tuberculosis, chronic obstructive pulmonary disease, alcohol withdrawal, stab wounds, fractures, pancreatitis, hepatitis, and gastrointestinal bleeding. Psychiatric problems that required hospitalization included schizophrenia, bipolar manic disorders, depression and psychosis. Many of the homeless patients had a high incidence of episodic and chronic problems that resulted in frequent hospitalization. Almost 40 percent of the patients were admitted several times to San

Francisco General Hospital during the seventeen-month period that the study was conducted.

The homeless in San Francisco are considered to be frequent users of medical services. Individual interviews of 170 homeless persons housed at an emergency shelter in April, 1984 revealed that 61.2 percent had received medical services during the previous three months and 76 percent had received medical services during the previous year.

Thirty percent of those interviewed stated that they had been hospitalized for psychiatric problems. This suggests a significantly high incidence of severe mental illness among the homeless since only the most severely mentally ill are hospitalized. Despite this high incidence, however, less than 23 percent of those interviewed stated that they had received psychiatric services during the previous year.

Homeless persons are especially vulnerable to sexual assault. Review of the medical records of over 350 sexual assault victims treated in 1983 at the Sexual Trauma Services in San Francisco indicated that more than nine percent of the treated sexual assault victims were homeless at the time of the assault. Half of the victims had injuries, ranging from major trauma such as skull fractures to minor trauma such as sprains and abrasions. All of the victims experienced some degree of psychological trauma.

The homeless also suffer a wide range of less severe medical problems. Review of the medical records of 524 homeless patients treated in 1983 at Central Emergency and 88 homeless patients treated in 1983 at a medical clinic operated at Grace Cathedral Emergency Shelter indicated that the homeless suffer a broad range of acute problems such as infestations, lacerations, upper respiratory infections, bronchitis, and cellulitis, and a wide range of chronic health problems, such as hypertension, foot problems, and dental problems.

Oftentimes, homeless people who have suffered lacerations wait too long before seeking medical assistance and do not return for follow-up care as needed. This may result in wound infections, prolonged disabilities and other complications which could have been prevented.

Homeless youth suffer many special medical and psychiatric problems. Review of the medical records of hundreds of homeless youth (14 to 19 years old) treated in the Adolescent Service at San Francisco General Hospital revealed a wide range of medical problems, including infections, sexually transmitted diseases, substance abuse, psychosomatic disorders, untreated injuries, and a broad range of mental health problems including personality disorders, acute anxiety reactions, and adjustment reactions. Among a sample of 40 homeless youth at San Francisco General Hospital, 62.5 percent were depressed or exhibited self-destructive behavior, and 55 percent had a history of past suicide attempts.

Health Resources

There is a wide range of medical and psychiatric services available in the Tenderloin/South of Market area, where many of the city's homeless gather. All of these programs, however, operate at or near capacity because of space and funding limitations, and are therefore unable to meet the demand for services. These programs include:

- St. Anthony's Clinic, which is located next to a soup kitchen where approximately 2,300 persons receive free meals and other services daily, and which provides comprehensive primary care for adults and children.
- The South of Market Health Center, which also provides comprehensive primary care to adults and children. About 15% of the Center's monthly 1,400 patient visits are by homeless persons.
- Central Emergency, which provides twenty-four hour a day treatment for minor medical and surgical problems. Approximately 20% of the clinic's monthly 2,000 patient visits are by homeless persons.

San Francisco's Department of Public Health operates a variety of mental health services in the Tenderloin/South Market area. About 20 percent of these programs' clients are homeless. Other Health Department programs serving homeless and other indigent persons in the area include the Sexual Trauma Service and the City Clinic, which provides comprehensive evaluation and treatment of venereal disease to over 4,000 patients monthly.

Although not located in the Tenderloin/South of Market area, the San Francisco General Hospital, which is the designated provider of inpatient services for indigent persons, is the major health facility available to homeless persons in the city. About eight percent of the hospital's admissions each month are for patients who are homeless. It is not known what proportion of the visits to the hospital's emergency and outpatient departments are by persons who are homeless.

Barriers to Care

Despite the availability of these services, however, there are many obstacles that prevent homeless persons from receiving adequate health care including:

- *Inaccessibility of service:* Difficulties in identifying health service sites and making appointments, long waiting period for non-emergency as well as emergency care, geographic separation of San Francisco General Hospital from the area where most of the homeless are present.
- Inadequacy of services to meet the broad range of medical and psychiatric problems of the homeless.

- *Inadequate health care treatment:* Negative attitudes of health professionals toward patients who are unkempt, abusive and mentally ill, inadequate follow-up treatment, inadequate coordination among medical, psychiatric and social service providers.
- Low priority given by homeless persons to medical and psychiatric care as a result of lack of knowledge or understanding of their need for health services, their self-destructive behavior, and dissatisfaction with prior encounters with specific medical or psychiatric services.

SAN JUAN

Demographics

San Juan estimates that two main groups of homeless are present in the city: traditional, including the deinstitutionalized, and new or temporary. Among the traditional homeless are "street homeless," and "SRO homeless." The new or temporary homeless are thought to include people who, as a result of family crisis, are unable to remain in their homes. Aggregate numbers of the homeless in San Juan are not available.

The applicant coalition estimates that more men than women are homeless, with the age range concentrated between 21 and 60 years.

Reasons for Homelessness

Pervasive poverty appears to be the leading cause of homelessness in San Juan. The application states that only 39 percent of the over-16 population is employed.

Health Needs

Using homeless patients served at a health center as a sample, San Juan estimates that alcoholic problems and malnutrition are the most frequent health problems seen in homeless people. More than 70 percent of the homeless seen in the health center had these problems. The coalition estimates that some 25 percent of homeless experience diseases of the upper respiratory tract and those related to ENT. Other problems included infection, dermatological disease, dental problems.

Psychiatric problems were seen in 69 percent of the homeless population served at the center. Half of the homeless population suffers from alcoholic psychosis, e.g., delirium tremens, hallucination, etc.

Health Resources

A very limited number of health services are available to San Juan's homeless. As private providers will not offer services to people who are unable to pay, and as homeless have few resources and most receive little or no Medicaid assistance, public providers are the providers of last resort. The San Juan Health Department offers the only inpatient and outpatient care for the homeless.

Barriers to Care

The application states "For those homeless people who do not live in shelters but live in SRO's or in the streets there are no available services or outreach activities." Care is difficult to obtain in emergency rooms and other public facilities because staff are reluctant to treat the homeless.

Other barriers to care include private health care facilities' reluctance to treat people who are unable to pay for care. Finally, homeless people are not inclined to seek health care because it is not priority and because the system is difficult to manage, i.e., long waiting periods, little follow-up, etc.

SEATTLE

Demographics

Seattle's Department of Human Resources estimates that on any given night, there are between 2,000 and 3,000 homeless people in the city. The U.S. Department of Housing and Urban Development estimates that the city's homeless population is 3,250. According to Seattle's Health Department the number of homeless people is between 15,000 and 25,000.

While the majority of Seattle's homeless use the shelter system, many do not. On a particular night in November, 1982 Operation Nightwatch, an outreach program for the homeless, found more than 300 men and women sleeping outdoors, under bridges, in parking garages, in cars and in bus stations. A year later, a similar survey found approximately 400 individuals sleeping in such places.

In addition to persons sleeping in shelters or in the streets, a significant number of people are living in overcrowded temporary situations and are at high risk of becoming homeless. Often, as many as two or three families double up in small apartments, with 10 to 15 people living in one-bedroom apartments. This problem is particularly acute among Seattle's minorities: Asian, Blacks, Native Americans and Hispanics.

A 1984 survey showed the following demographic profile of Seattle's homeless population: 61 percent of the homeless are men; 18 percent are women; and 21 percent are children. Almost half of the homeless people in Seattle are members of minority groups (compared to only 20% of the city's total population); 25 percent of all shelter clients are Black, 10 percent are Native Americans, nine percent are Hispanics. Approximately 63 percent of the homeless housed in the shelters are single individuals. The remainder are families, approximately half of which are headed by single parents with children.

The specific demographic characteristics of Seattle's homeless population vary according to the geographic subareas of the city where the various homeless groups congregate. For example, the homeless population in the downtown area is characterized by a high number of single men, many of whom are alcoholics, mentally ill, elderly, and/or veterans. In the Northern area of the city, the homeless population consists primarily of women and children. While a majority of them are White, there is a growing number of minorities among this group. In South Seattle, the

homeless are primarily women and children. Over 60 percent of the homeless people in this area are minority.

Reasons for Homelessness

There are several major factors which influence the size and characteristics of Seattle's homeless population, including:

- Migration of people to the city in search of jobs and better opportunities.
- High unemployment rates, which averaged nine percent during the past year.
- Inadequate levels of public assistance, which cover at most 65 percent of basic living requirements.
- Lack of housing affordable by low-income people.
- State mental health policies which have resulted in the release of significant numbers of mentally ill persons, many of whom are now living in Seattle's jails, hospitals, or in the streets, without medication or treatment.
- Insufficient services for substance users.
- High concentration of Southeast Asian refugees, most of whom have few job skills, no financial resources, and know little English.

Health Needs

Approximately 45 percent of the homeless persons interviewed in two separate surveys conducted in Seattle 1984—one by the city's Department of Human Resources, the other by the Seattle/King County Human Services Coalition—reported a need for health care services. Among the common problems identified were upper respiratory infections, injuries, and chronic illnesses related to malnutrition, alcoholism and drug abuse. Almost half of the respondents to the city survey indicated a need for dental services. Shelter staff reported, however, that about 75 percent of their clients could benefit from dental care. Twenty-eight percent of the respondents reported a need for mental health services. Again, shelter staff believed this estimate was an undercount, indicating that over 50 percent of their clients were in need of mental health treatment. Incidences of chronic mental illness are more common among homeless single women and men in the downtown area of the city, while homeless families in the South and North areas tend to have more "situational" mental health problems.

In terms of substance abuse, 25 percent of the single males interviewed stated that they could benefit from drug or alcoholism treatment. Staff of the Downtown Emergency Service Center, however, estimate that almost 60 percent of their clients are substance abusers. According to the staff of

the Onion Center, which serves homeless youth in the downtown area, about 90 percent of their clients are drug or alcohol abusers.

Health Resources

Health care services available to homeless and other indigent persons in Seattle include those provided by the following facilities:

- Seventeen community-controlled health centers, which are part of the Seattle/King County Community Clinic system.
- Several other ambulatory care clinics which are affiliated with local hospitals.
- Three service centers, operated by the Seattle Division of the Health Department.
- Five public programs for inpatient alcoholism services.
- King County Division of Human Services, which provides community mental health services, including support services, day treatment, as well as chemical dependency programs and other services.
- Harborview Medical Center and the Highline Evaluation and Treatment Facility in Seattle, and the Western State Hospital near Tacoma, which provide inpatient services for the mentally ill.
- Two mental health projects, with a combined bed capacity for 45-50 clients, which serves mentally ill persons in the downtown area.

Barriers to Care

Homeless persons in Seattle, as those in other cities, experience significant difficulties in accessing the health care system. Subsequently, they often do not receive the assistance they need. For example, health department staff estimate that 45 percent of the 109 active cases of tuberculosis reported last year in the city were found in homeless persons. While the resources available for TB care in Seattle are generally adequate, they often do not reach the homeless.

There is clearly insufficient health care services available in Seattle for indigent persons, particularly the homeless. Homeless persons' access to whatever resources are available is further limited by several factors, including lack of money, of information about the programs, and of motivation to seeking health care on their own. Only 20 percent of the homeless individuals interviewed in one of the aforementioned surveys indicated they had Medicaid or other resources to pay for health care. Over 80 percent of those needing medical care had no means of transportation to get to health care facilities. Poor self-image and a sense of hopelessness further prevent homeless persons from seeking or following through with medical services. Also, homeless persons move often from one shelter to another, making referrals and follow-up treatment particularly difficult.

TUCSON

Demographics

A survey conducted in January 1984 identified over 1,700 homeless individuals who were receiving services from fourteen agencies in Tucson. This number is approximately half the city's estimated homeless population. Based on the survey sample, the "typical" homeless person in Tucson is a single Anglo male, between the ages of 18 and 40. The survey also revealed the following information:

- 75% of the homeless in the city have been dislocated as a result of economic reasons, such as recent unemployment.
- 15% are disabled, retired, or unable to work.
- 10% exhibit some form of identified behavioral health problem. (It should be noted, however, that the survey design is believed to have resulted in an undercount of this segment of the homeless population and that the actual figure could be as high as 30%).
- 5 to 10% of the homeless are labeled as "career transients."

Reasons for Homelessness

The following are considered to be major causes of the problem of homelessness in Tucson:

- *Unemployment/migration from other cities:* Official statistics do not reflect Tucson's actual unemployment rate since they include neither the many unemployed workers who have exhausted their benefits or have become discouraged, nor new arrivals from other areas. As a result, many city residents and migrants from other areas who have been attracted by the city's supposedly low unemployment rate face great difficulties in gaining employment.
- *Migration from Arizona's rural areas:* Fluctuations in the State's economy has caused significant migration of unemployed people from rural and small town communities who go to the city in search of jobs. They include miners, Native Americans from nearby reservations, and migrant farm workers.
- *Deinstitutionalization and lack of mental health services:* Significant numbers of chronically mentally ill persons are now living in the community as a result of deinstitutionalization policies. Services

needed by this population, however, are scarce in Arizona, which ranks 49th in the nation for funding behavioral health programs.

- *High cost of housing:* A high percentage of the housing available in Tucson is post 1940's and has a higher rental price than in other communities with older housing stock.
- *Inadequate services for alcohol abusers:* Despite significant increases in the need for these services, bedspace in programs for the indigent alcoholic in Tucson has decreased below 1971 levels.
- *Immigration:* Economic and political conditions in Mexico and Central America have caused thousands to flee their countries and seek work in the border states, thus increasing competition for scarce jobs.
- *Inadequate levels of public assistance:* Welfare benefits, which are limited to disabled workers and non-working single parent households, are commensurate with 1971 standards of need.

Health Needs

The major health problems of the homeless in Tucson are similar to those experienced by homeless persons in other parts of the country with a few exceptions which are unique to the area. These include trauma related problems, such as lacerations and abrasions, scabies and lice infestations, respiratory problems ranging from URIs to pneumonia and, in the summer months, dehydration and sunburn. The homeless are also at high risk of contracting tuberculosis due to their chronically poor nutritional status and the general lack of adequate hygiene in their lifestyle. In addition, homeless persons in Tucson are predisposed to contracting Cocci or Valley Fever, since they often sleep outside on the ground where the fungus is harbored in spores. Although not contagious, this illness can have very debilitating effects in the acute phase. Without adequate rest or nutrition, which homeless persons lack, recovery is prolonged.

Health Resources

Most of the health care services sought by homeless persons in Tucson is provided in hospitals' emergency rooms and walk-in clinics. During 1983, four of the city's seven hospitals which are often utilized by the homeless provided health care, including emergency services and out-patient care, to approximately 6,000 patients whom they identified as homeless.

Four out-patient clinics are located in the same geographic area as these hospitals. The Pima County Health Department also operates a number of specialized clinics. Mental health services are available on an out-patient basis at three central locations. They include a private, non-profit comprehensive mental health center which offers a wide range of

counseling and substance abuse services and two community centers operated under the authority of the Arizona Department of Health Services. Inpatient mental health services are provided at two public hospitals on a limited basis, with a total of 51 beds in the two institutions. Psychiatric treatment is also provided at three private hospitals.

In an effort to reach people who are chronically mentally ill and who are currently not in treatment, The County's Kino Community Hospital recently established a "mobile crisis team." This new program will be utilized to assist homeless mentally ill persons.

Services for alcohol abusers in Tucson are offered at three hospitals and at seven residential treatment programs. Services for drug abusers include ten drug-free counseling programs, and two long-term residential treatment programs which take clients on a sliding fee basis.

Barriers to Care

It is not known how many of the people served by Tucson's health care programs are homeless. However, health services are generally out of the reach of homeless persons. According to the applicant "access to health care is a critical problem for homeless persons in Tucson." Only 9 percent of the homeless individuals who participated in a survey reported they were receiving health care, even though 34 percent indicated a need.

Major barriers which prevent homeless people from receiving health care include a shortage of beds in residential treatment facilities for people with behavioral health problems, lack of transportation and lack of effective case management services with decentralized intake services.

Most important, however, is the difficulty experienced by homeless individuals in qualifying for the State's Medicaid Option program, the Arizona Health Care Cost Containment System (AHCCS). The AHCCS program is a three year project initiated in October 1983 to demonstrate the viability of the pre-paid/flat rate (HMO) concept as an alternative to Medicaid. Under this system, eligible clients are assigned to an AHCCS provider who is responsible for providing a full range of health care services to their client population for a fixed monthly fee paid by the AHCCS program directly to the provider. Prior to AHCCS, medical care for the poor in Tucson was limited to emergency and in-patient care through the County's community hospital. Because of the program's regulations concerning residency and proof of income requirements, it has been difficult for homeless individuals, particularly those who are chronically mentally ill or substance abusers, to become certified for the AHCCS.

WASHINGTON, D.C.

Demographics

The Nation's capital contains a segment of the homeless population found nowhere else. The so-called White House homeless come to Washington to present an agenda to the President or the Congress. After arriving they do not have the resources to leave, nor do they have the resources to remain. How large a group of the Capital's homeless fall into this category is not known, chances are it is relatively small.

Estimates provided by the Community Foundation of Greater Washington on behalf of the city's coalition show some 5,000 homeless in Washington at any one time. Eighty-five percent are Black; 40 percent have mental health problems. It is believed that 70 percent of all homeless women have mental health problems and 10 percent have alcohol problems. Of homeless men, 55 percent are thought to have alcohol problems. More complete data were being developed while the application was under preparation.

Reasons for Homelessness

Homelessness in Washington is attributed to a number of factors including:

- 12% unemployment.
- Deinstitutionalization of chronically mentally ill people from St. Elizabeth's Hospital, a federal facility, "into local communities which lack adequate mental health and shelter facilities, and the uncertainty of the federal government's willingness to financially assist the city with this problem."

In addition, the application lists: the large number of families on public assistance; limited affordable public housing; cutbacks in federal support for health and human service programs that impacted upon the District to a greater extent than in any of the 50 states; and, arrival in Washington of large numbers of illegal and legal refugees from Central America.

Health Needs

The application cites the limited available information in this area. Mental health problems are high on the list of health difficulties, again as a result of deinstitutionalization. Other health problems include: dental

(28% of men and 22% of women); injuries due to assault (21% of men and 19% of women); foot problems (24% of men and 29% of women); hypertension (19% of men and 14% of women). Alcohol problems were cited as the second most severe problem for homeless men.

Health Resources

Current health resources for homeless people include a number of public and private facilities. The application lists 11 private clinics and 13 hospitals (a number of which are in sections of the city far from areas where the homeless congregate). Public facilities include 16 city-run ambulatory clinics serving people with "low or no income." Major support for these services now comes from city appropriations, Medicaid and health block grants.

A small number of the health services in Washington are set up specifically for the homeless. Included are:

- A dental and medical clinic housed in a soup kitchen, serving an average 20 and 25 people per day, respectively.
- A private convalescent shelter for homeless men and women recovering from injury or illness; there are 16 beds available, with services provided by full-time live-in volunteers.

Barriers to Care

The major barrier to care is the relatively small number of resources present to serve the large number of deinstitutionalized people who are unable to function without support services. The application notes the following gaps in health services for the deinstitutionalized mentally ill: insufficient on-site medical treatment; inadequate support services; and, insufficient public-private coordination.

APPENDIX

City Contacts

*Albuquerque**

Rev. Stan Gourd
509 Second Street, S.W.
Albuquerque, NM 87102
or
P.O. Box 331
Albuquerque, NM 87103
(505) 242-3181 (Alliance Health
Care Line)

Atlanta

Robert Parrish, Jr.
Associate Director
Grady Memorial Hospital
80 Butler Street, S.E.
Atlanta, GA 30335
(404) 588-4831

Austin

Albert G. Randall, M.D.
Director
Austin-Travis Health Department
15 Waller Street
Austin, TX 78702
(512) 469-2084

*Baltimore**

Hope Gleicher
Health & Welfare Council of
Central Maryland, Inc.
22 Light Street
Baltimore, MD 21202
(301) 752-4146/Ext. 519

*Birmingham**

Karen Carney
c/o Housing Authority
Birmingham District
P.O. Box 55906
Birmingham, AL 35255-5906
or
Birmingham Housing Development
Corporation
1826 Third Avenue, S.
Birmingham, AL 35233
(205) 252-9624 or 9678

*Boston**

Eileen M. Brigandi
Boston Health Care for Homeless
818 Harrison Avenue
Boston, MA 02118
(617) 424-4623

Buffalo

Mary Jo Anderson
President
Adult Residential Care Advocates, Inc.
525 Washington Street
Buffalo, NY 14203
(716) 856-4494

Charlotte

Boyd F. Cauble
Assistant to the Mayor
600 E. Trade Street
Charlotte, NC 28202
(704) 374-2244

*Chicago**

Jean Summerfield
Travelers & Immigrants Aid of Chicago
327 South LaSalle-Room 1500
Chicago, IL 60604
(Temporary Address)
(312) 435-4500

Cincinnati

Theodore Hall, Jr.
Planning Director
Community Chest and Council of the
Cincinnati Area, Inc.
2400 Reading Road
Cincinnati, OH 45202
(513) 762-7160

*Cleveland**

Rudolph (Rudy) K. Kump
Cleveland Health Care for the
Homeless Program
c/o Federation for
Community Planning
1001 Huron Road
Cleveland, OH 44115
(216) 781-2944/Ext. 351

*Indicates recipient of Program award; individual listed is project director or temporary contact person.

Columbus

David Hamilton
President
Metropolitan Human Services
Commission
360 South Third Street
Columbus, OH 43215
(614) 224-1336

Dallas

Callie Foster Struggs
Director
Department of Health and
Human Services
1500 Marilla Street
Dallas, TX 75201
(214) 670-5216

*Denver**

Mary Ann Gleason
Colorado Coalition for the Homeless
2100 Stout Street
Denver, CO 80205
(303) 832-4508

*Detroit**

Sue Wilensky
United Community Services
51 W. Warren Avenue-Room 218
Detroit, MI 48201
(313) 831-5544

El Paso

Rhoda W. Tillman
Director of Public Services
West Texas Council of Governments
2 Civic Center Plaza
El Paso, TX 79999
(915) 541-4681

Fort Worth

B. Brooks Taylor, M.D.
Director of Public Health
1800 University Drive
Fort Worth, TX 76107
(817) 870-7237

Honolulu

Sister Maureen Keleher
Chief Executive Officer
St. Francis Hospital
2230 Liliha Street
Honolulu, HI 96817
(808) 547-6011

Houston

James G. Haughton, M.D.
Director
City of Houston Health Department
1115 N. MacGregor
Houston, TX 77030
(713) 222-4311

Kansas City

Richard Biery, M.D.
Health Director
414 E. 12th Street
Kansas City, MO 64108
(816) 274-1381

*Los Angeles**

Jo-Ellen Murata
Assistant Professor
UCLA School of Nursing
Factor 3-246
Los Angeles, CA 90024
(213) 825-0817

Memphis

Gid Smith
Executive Director
Metropolitan Inter-Faith Association
P.O. Box 3130
Memphis, TN 38173-0130
(901) 527-0208

Miami

Linda S. Quick
Executive Director
Health Council of South Florida
3050 Biscayne Boulevard
Suite 600
Miami, FL 33137
(305) 573-0220

*Indicates recipient of Program award; individual listed is project director or temporary contact person.

*Milwaukee**

Tom Hickey
Coalition for Community Health Care
2770 N. 5th Street
Milwaukee, WI 53212
(414) 265-7514

Minneapolis/St. Paul

Lenora Sherard
Health Department Analyst
Minneapolis Health Department
250 S. Fourth Street
Minneapolis, MN 55415
(612) 348-4363

*Nashville**

John Lozier
Downtown Clinic
606 Demonbreun Street
Nashville, TN 37203
(615) 725-1530 or 1531

Newark

Patricia Robinson
Newark Health Planning
Administrator
110 William Street
Newark, NJ 07102
(201) 733-7558

New Orleans

Brobson Lutz, M.D.
Director of Health
1300 Perdido
New Orleans, LA 70112
(504) 586-4668

New York

Susan Neibacher
United Hospital Fund of New York
3 East 54th Street
New York, NY 10022
(212) 754-1080/Ext. 263

Oakland

Carl Smith, M.D.
County Health Officer
499 Fifth Street
Oakland, CA 94607
(415) 874-6192

Oklahoma City

Charles L. Marshall, Ph.D.
Research Associate
Oklahoma City-County
Health Department
921 N.E. 23rd Street
Oklahoma City, OK 93105
(415) 427-8651

Omaha

Robert V. Vining, D.D.S.
Associate Vice President for
Health Sciences
Creighton University
Omaha, NB 68178
(402) 280-2973

*Philadelphia**

Elaine Fox
Philadelphia Health Management
Corporation
841 Chestnut Street
12th Floor
Philadelphia, PA 19107
(215) 629-8222

*Phoenix**

Nancy McLeod
Assistant Human Resources Director
City of Phoenix
302 West Washington
Phoenix, AZ 85003
(602) 262-6666

Pittsburgh

John G. McCormick
Executive Director
Health and Welfare
Planning Association
200 Ross Street
Pittsburgh, PA 15219
(412) 392-3103

Portland

Don Clark
Executive Director
Burnside Consortium
222 N.W. Conch Street
Portland, OR 97209
(503) 223-5322

*Indicates recipient of Program award; individual listed is project director or temporary contact person.

St. Louis

A. Michael Klein
Division Director of Social Services
The Salvation Army
3800 Lindell Boulevard
St. Louis, MO 63108
(314) 533-6861

*San Antonio**

Weir Labatt
San Antonio Urban Council, Inc.
217 McCulloch
San Antonio, TX 78215
(512) 224-1756

San Diego

Howard DeYoung
Chief of Primary Care Services
6255 Mission Gorge Road
San Diego, CA 92120
(619) 560-3092

*San Francisco**

Bob Prentice
San Francisco Department of
Public Health
101 Grove Street-Room 323
San Francisco, CA 94102
(415) 558-2386

San Jose

Barry Del Buono
Executive Director
Emergency Housing Consortium of
Santa Clara County, Inc.
P.O. Box 2346
San Jose, CA 95109
(408) 748-8622

San Juan

Modesto Cobán, M.D.
Director
Coalition of Organizations to Serve the
Homeless in San Juan
G.P.O. Box B.R.
Rio Piedras, PR 00928
(809) 763-6560

*Seattle**

John Haynes
Fremont Public Association
P.O. Box 31151
Seattle, WA 98103
or
Fremont Public Association
710 N. 34th Street
Seattle, WA 98103
(206) 632-1285

Tucson

Daniels Duncan
Associate Director
United Way of Greater Tucson
P.O. Box 42588
Tucson, AZ 85733
(602) 323-7625

*Washington, DC**

Patricia N. Mathews
Vice President for Programs
Community Foundation of
Greater Washington
3221 M Street, N.W.
Washington, DC 20007
(202) 338-8993

*Indicates recipient of Program award; individual listed is project director or temporary contact person.